Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Month Year **Physician** 11:00A M 2010 Estelle May 15, Alva Armstrong /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** La Plata Charles Charles County Nursing Home & Rehab If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Months Days 1 □ M 2 F December 5,1910 99 Maryland 578-36-4918 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 2 should be filed within 12 moon and Mental Hygiene.
1 and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show marke event, inc. Predical Examiner must be rediffed at TYPE 2 NO Director MD Charles La Plata 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10200 La Plata Road 20646 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 □Yes 2 No Specify: White Specify: <u>م</u> 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper Service Station 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John L. Moore Mary Molly Windslor ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ron Kuklish/ Nephew 1585 Duberry Road, Finger, TN 38334 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Washington National Cem. 5/20/2010 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M00945 21. Signature of Euneral Service Licensee AREHARI-ECHOLS FUNERAL HOME, P.A. au 211 St. Mary's Ave. La Plata, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) De Oressi Due to (or as a consequence of): Examiner Physician/Medical 2 Completed

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, I

Baltimore, Maryland 21215-0036

Funeral

Director

law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

attending physician signed by the a has • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certifica funeral director, Be Certification: To the filled in by

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of): c. Due to (or as a consequence of): d									
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	23d. Date of delivery Month Day Year								
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknow								
		24a. Was an autopsy performed? 1 □ Yes 2 □ Mo 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No								
25. Was case referred to medical	26. Place of Death (Check only one)									
examiner? 1 Yes 2 X No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Ho	me 5 Residence 6 Other (Specify)								
27. Manner of Death 1 X Natural 5 □ Pending 2 □ Accident investigatio	(Month, Day, Year) Injury Work?	28d. Describe how injury occurred								
3 ☐ Suicide 6 ☐ Could not b	28e. Place of Injury - At home, farm, street, factory, office 28f, Location (Street and Number or Rural Route Nu									

determined 4 Homicide building, etc. (Specify) City or Town, State)

29a. Certifier (Check only

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) May 18, 2010

e and address of person who completed cause of death (Item 23a) (Type, Print)
Hussein, M.D. 5625 Allentown Rd. Suite 101, Camp Springs, MD

State Registrar

completely

To the within 2.

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 20, 7:30A.M 2010 Daniel Buchalter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fairland Nursing Home Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Days Hours Aug. 16, 1938 Washington, DC **Director** 578-52-9288 71 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10d. Inside City Limits Director Maryland Calvert Saint Leonard 1 🗆 Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 940 Calvert Beach Road 20685 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 XYes 2 No Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1962-1963 1 Yes 2 No Specify. iit. Page 1 and 2 should be filed within 72 nours arment of Health and Mental Hygiene. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Technician Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathan Buchalter Sara Buchalter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barry L. Polisar -nephew 3605 Dustin Road Burtonsville, Maryland 20866 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 5/20/2010 Alexandria, Virginia 21. Signature of Funeral a rvi e Licens Bonald Avers Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death h sician/ Acute Cardiopulmonary Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Encephalopathy osquentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) End stage Renal Failure Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed g physician and strans Due to (or as a consequence of) resulting in death) Last Physician/Medical Coronary Artery Disease Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Pregnant at time of death 2 No ate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Yunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Ves 2 X No 1 ☐ Yes 2 XNo Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 ☐XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) 24 hours Medical 29a. Certifier 1 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 | Medical Examiner: On the basis of examination and of involged in the property of the basis of examination and of involged in the property of the basis of examination and of involged in the property of the basis of examination and of involged in the property of the basis of examination and of involged in the property of the basis of examination and of the property of the basis of examination and of the property of the basis of examination and of the property of the basis of examination and of the property of the basis of examination and of the property of the basis of examination and of the basis only one) 29b. Signature and title of certifi 29c. License number D63232 May 20, 2010 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Patricia Gomez,

Shady Grove Road,#130 Rockville, Maryland 20850

15245

Regist ar's Signature

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not instit 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice Randallstown Baltimore Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Davs Hours (Month, Day, Year) 2-27-1937 Country) **Director** 222-22-4824 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director 28a-f 1 X Yes 2 No MD Baltimore Baltimore 10f. Zip Code 10e. Street and Number ò 10g. Citizen of What Country? Funeral items 23a 7508 Reserve Circle, Apt 102 21214 USA permit. Page 1 and 2 should be flied within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event: the Machine 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black White etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: Black 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Peninsula Regional Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant Medical Center 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James E. Mills Ella Collick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Duawan Mills/Daughter Robinson St. <u>Salisbury, MD 21801</u> 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5/22/2010 Girdletree, 4 ☐ Donation 5 ☐ Other (Specify) Springs Cem Name and Address of Facility
nnie_Smith 917 W. 22. Name and Bennie Isabella St. Salisbury, Funeral Home 23a. Part 1. Enter the disease or complications that shock, or heart failure. List only one cause on death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Enysician/ 6 ı disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 **N**0 Other: ٩ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA To the Funeral Director; After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Suicide 6 Could not be Plac of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 3mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Monti

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 KobERT BONNER 58 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death omic 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 ₺M 2 □ F Months Hours Min (Month, Day, Year) Director 23-58-6218 Yrs. ieginia Usual Residence of Decedent 28a-f shov 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director SALISBURY 1 ☐ Yes 2 🔼 No ARYLAND 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21801 USB 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Avo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married <u>م</u> Nobert Bonner Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) NONE 12 LABORER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည BONNER BESSIE BONNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau BONNER #210 6 EVEUN Pack 9 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify ARSONS Salisbuey, Md 21. Signature of Funeral Service Li 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE CARDIOMYOPATH disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Ym PHOMA Sequentially list conditions Examine Due to (or as a consequence or): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): nding physician a use as the burial-Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Ď 4 ☐ Pregnant at time of death 9 ☐ Unknown Day ed by the a detached f P.O. been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy certificate Yes 20 1 Yes **Division of Vital** director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this funeral n 24 hours after death.

e Funeral Director: After the bleted filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 5 mg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ha why legistrar's Signat State MAY 19 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Steven Paul Medical May 2010 11:40A M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery . Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country)
 Czechoslovakia **Funeral** 8. Date of Birth 1 🔀 M 2 🗆 F Months Days Hours Min (Month, Day, Year, an 24, 1 Director 215-44-4905 64 1946 Jan Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medi al Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland 1 Yes 21 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14404 Georgia Avenue 20853 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 2 1 X Never Married 2 Married 2 **M**lo Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 2 Electronic Technician Electronics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury over 2. 2 Jan Reno Sophie Klara Kroneraf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Roman Beno/brother 14404 Georgia Avenue Rockville, Maryland 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 5/16/2010 Woodbine, Maryland 21. Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784 Thomas anto M00957 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Medical Onset and Death Sepsis disease or condition resulting in death) Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): burial-transi Cause (Disease or iinjury Coronary Artery Disease that initiated events resulting in death) Last Due to (or as a consequence of nding physician are as the burial Physician/Medical certificate be Chronic Atrial Fibrillation IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery atter 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No ō Day Year oy the signed of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> Records, Cirrhosis Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Ja performe Yes 2 X No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 No မ 1 Nation 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? r death. ours after death leral Director: A filled in by the f Accident 2 🗆 No Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Vita of Hospital or Attending Division 24 hours pleted 1

Box 68760

P.O.

State Registrar (Check

only one) 29b. Signature and title of

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated,

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 M

18101 Prince Philip Drive Olney, Maryland 20832

DHMH 17 Rev 7/2009

Registrar

P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May 2010 21 9:15 a. M Edward Barber Marvin 4a. Facility Name (if not institution, give street and number)

Months

7. Age (In yrs. last birthday)

82

4b. City, Town, or Location of Death

Tall Timbers

Hours

If Under 1 Year If Under 24 Hrs.

4c. County of Death

8. Date of Birth

03/08/1928

St. Mary's

g. Birthplace (State or Foreign

Washington, DC

Physician/ Medical **Examiner**

Funeral

18314 River Road

1 🖾 M 2 🗆 F

5. Social Security Number

579-34-1522

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tieme 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Physiciar Medica Examine

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Usual Residence of Decedent										
Director	10a. State 10b. County 10c. Cit	y, Town or Location									
1 5	Maryland St. Mary's	Tall Timbers			1 🗌 Yes 2 🎦 No						
	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?						
le le	18314 River Road	206	90	USA							
Funeral	11. Marital Status 12. Was Decedent Ever in U. Armed Forces?		ispanic Origin? (Specify Yes or N In, Mexican, Puerto Rican, etc.)		14. Race - American Indian,						
yd by	1 ☐ Never Married 2 XXMarried 1 XX Yes 2 ☐ No If Yes, Give 1 Year or Dates.	1 ☐ Yes 2X No	Specify:		Black, White, etc. Specify: White						
lete	15. Decedent's Education	16a. Decedent's Usual Occup	ation	16b. Kind of Business	16b. Kind of Business Industry						
Completed	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	(Give kind of work done life. DO NOT use retired,	during most of working								
	12	Security Off	icer	Federal G	Federal Government						
	17. Father's Name (First, Middle, Last) Marvin G. Barber 18. Mother's Name (First, Middle, Maiden Surname) Mary L. Lyons										
=											
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
	Marilyn Miller Barber/Wife	18314 River	Road, Tall Tim	bers, MD 206	90						
		Place of Disposition (Name of cemetery, crematory or other pla	ce) Date	20c. Location - City of	r Town, State						
1	4 Donation 5 Other (Specify)	insfield-Echols	05/27/2010	Charlotte	Hall, MD						
	21. Signature d'uneral 8 du le Licens		ss of Facility Brinsfie								
	Edward N. Brinsfield, Jr. M00		lywood Rd., Led		D 20650						
	23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	^	/	arrest,	Approximate Interval Between						
/	Immediate Cause (Final disease or condition Acade n	lyocardrof a	Infanc toon	_	Onset and Death						
]	resulting in death) Due to (or as a consequence of the consequence of	uence of):	0.	/ c							
<u></u>	Sequentially list conditions, L. Allens		nelwordscal	as Actorise) Centrow						
nju	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of the consequence)	uence of):									
xan	Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of the consequence)	uanas aft									
<u>a</u>	resulting in death) Last Due to (or as a consequence)	uence on):									
ig	d										
Ž	IF FEMALE: 23b Was decedent pregnant 23c. If yes, outcome of pregnant	inov.									
lai	in the past 12 months?	al death 3 🗌 Ectopic pregnan	;y	23d. Date of do Month	elivery Day Year						
Sompleted by Physician/Medical Examiner	1 Yes 2 No 4 Pregnant at time of 0 9 Unknown 9 Unknown	death 5 Other (specify) _		- 1001111	Day Teal						
1	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause gi	ven in Part I. 23e. Die	d tobacco use contribute t	o the cause of death?						
P P	Scalets Mellitus										
ete	b / A company the										
ΙĒ	Hyper Cousine Cardis Nosca landisca 24a. Was an autopsy performed? Page 124b. Were autopsy findings availabe prior to completion of cause of death?										
1-											
l a	examiner? 1 Yes 2 No Hospital: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 No Residence 6 Other (Specify)										
12											
cate											
E	27. Manner of Death Manual S Pending Investigation Suicide A cluid Suicide A cluid Homicide Pending Investigation Suicide A cluid Homicide Pending Investigation Suicide A Homicide Pending Investigation Suicide Pending Investigation Suicide Pending Investigation Suicide Pending Pending Pending Investigation Suicide Pending										
ပြီ											
ica	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
Med	(Check 2 ☐ Medical Examiner: On the basis of examination only one) 3 ☐ Certifying Nurse Practioner: To the best of my	n and/or investigation, in my opini	n, death occurred at the time, dat	e and place, and due to the	cause(s) and manner stated						
	29b. Signature and title of certifier	29c. Licens		29d. Date signed (Mon							
	I homas / faul (a	1	0104	May 25, 20	10						
	30. Name and address of person who completed cause of death (Item	23a) (Type, Print)	, <u> </u>								
	Thomas Havell 4201 Cathedral	Avenue N.W. Was	hington, DC 20	0016-4929							
ate	31. Date filed (Month, Day, Year) 32. Registrar's Signar										
rar .	MAY 2.7 2010 12	B had									

Regis DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2010 Melvin Jerome Bannister 22, 1:07 p.mW Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🛣 M 2 🗆 F Days Hours Country) Maryland 02/20/1967 Director 562-83-3362 43 Yrs. Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25860 Morganza Turner Road 20659 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give within 72 hours after Maryland 21215-0036 nan "natural", Medical Exar 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Completed Specify: Year or Dates Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Home Improvement Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever Page 1 and 2 should be ment of Health and Ment George Robert Bannister Agnes G. Nelson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trai once. Agnes G. Bannister/Mother <u>25860 Morganza Turner Road, Mechanicsville, MD 20659</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Cem 05/28/2010 | Leonardtown, MD Stores de 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complication and caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) munit Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the attending physician and hed for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has Hospital or Attending Physician; The I 24 hours after death. performe After this certificate 1 🗌 Yes 2 🗆 No of Vital completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital 1 🗆 Yes Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending Division 2 Accident 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2010

Barni

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 19, 2010^{ay} Ш James Gardner 9:45 AM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 6704 Tall Oak Drive Temple Hills Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 √2 M 2 □ F Hours Min. (Month, Day, Year) Director 218 26 5945 79 Virginia Aug 7 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at within 72 hours after death with the Maryland Director 10d. Inside City Limits Temple Hills Maryland Prince George's 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 6704 Tall Oak Drive 20748 United States 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 Married Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: ¾¥ Widowed 4 □ Divorced Korean White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Real Estate Broker/Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James G. Bare, Jr Frances Leo Haves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1302 Matthew Drive, Huntingtown, MD 20639 James G. Bare, IV (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Maryland Veterans Cemetery 1 X Burial 2 Cremation 3 Removal from State May 26, 2010 Cheltenham, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one caus s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ resulting in death) Medical Gips. Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Yes 2 No 9 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After 1 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

BB 104

Columbia, MD 2104

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

10710 Charter Drive

32. Régistrar's Signature

Deborah Frassica, M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State of Maryland / Department of Health and Mental Hygiene Registrar DOR/5/25/10, LDB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4:53AM Physician/ Month OS Doris Lee Bailey Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death Examiner County of Death isbuil Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. / 8. Date of Birth 9. Birthplace (State or Foreign Funeral Feb. 25, 1930 Mary Land 1 □ M 2 🏋 F Hours 217-28-2805 80 Director Usual Residence of Decedent show 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Maryland Wicomico Salisbury 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1103 Schumaker Drive, Apt. 109 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examit Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Howard Edward Phillips Agnita Bradley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul T. Bradley/Son 610 Woodbine Avenue, Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland Veterans Cem. 6/3/2010 4 ☐ Donation 75 ☐ Other (Specify) Beulah, Maryland Zeller Funeral Home, P. O. Box 207 106 Main Street, East New Market, MD of Emeral Service 21631 and 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one eause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 4 Pregnant a Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ₽ 9 ☐ Unknown is certificate has been signed by director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate be completed filled in by the funeral director, page 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 R Other (Specify) Hospital: 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🛣 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) မ 05-16-2010 29505 . Name and address of person who completed cause of death (Item 23a) (Type, Print) 5302 CHINABERRY DR., SALISBURY, MD 21801 GREGORIOM. BELLOSO, M.D.,

Registrar
DHMH 17 Rev 7/2009

State

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sr Ronald Delano Barnes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany WMHS- RMC Cumberland Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Month, Day, Year) 40 Months Hours Director 213-40-3487 69 Usual Residence of Decedent marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Bedford Artemas 1 ☐ Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 139 Memory Lane 17211 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status Race - American Indian. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Columbia Gas Co station engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Watson Barnes Margaret (Clingerman) Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
139 Memory Lane Artemas PA **Deborah Barnes** 17211 wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Fairview Christian Cemetery 1 X Burial 2 Cremation 3 Removal from State 6/3/2010 PA Inglesmith 4 Denation 5 Other (Specify) dignature / 22. Name and Address of Eacility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Par/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Myoca disease or condition resulting in death) -dau Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine il dry, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by i completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy perform 25. Was case referred to medical examiner?
1 ☐ Yes 2 📉 No Be 26. Place of Death (Check only one) ပ 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

Dy

State

29b. Signature and title of certifie

WONSOCK 31. Date filed (Month, Day, Year)

norsochsten

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

925

32. Registrar's Signature

Bishop

00055325

Cumberland MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1715 **Bridges** Carol Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Health Nur. and Rehab. Ctr. Cumberland Allegany 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Yea Jun 18, Funeral 1 🗆 M 2 🗆 🕊 214-46-3191 **Director** 63 Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Allegany Mt. Savage MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13714 Lab Lane N.W. 21545 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates white Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) seamstress Blouse Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wanda Lee (Atkinson) Spencer Lorenzo Junior Spencer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 13714 Lab Lane N.W. Mt. Savage MD 21545 Francis Bridges husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P A. 20a, Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Kemation 3 Removal from State 5/29/2010 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) ignature of Funeral Service 22. Name and Address of Fecility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Page 1. Enter the disease, or complications that caused spock, or heart failure. List only one cause on each line. ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician, disease or condition resulting in death) CORONARY Cok Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag 2 1 Yes 2 No 1 Tyes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W 31. Date filed (Month, Day, Yea istrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
Amend Item 3 per med cert 6907 9/23/10 dk
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^D2010 Robert Ennalls Powell Cannon may 16, 6:17 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Salisbury 720 Riverside Drive Wicomico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F 93 Hours Min 03/25/1917 Mary land Director 214-10-7523 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho miportant: If tiem 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Wicomico 1 Yes 2 No Maryland Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 720 Riverside Drive 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Armed Forces by Black, White, etc. 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 res, Give Army Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) law attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ಲ Daniel B. Cannon Miriam E. Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilda Cannon/spouse 720 Riverside Dr., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Parsons Cemetery Salisbury, MD 5/20/2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licenses 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or linjury that initiated events Examine Due to (or as a consequence of): I or Attending Physician. The law requires that the death certificate be executed after death. attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1 No 1 ☐ Yes 2 ☐ No Yes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical sempleted filled in by the funeral director, Is 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Nula 047094 5/18/10 VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sheet SALISAVMY MD 21804 1415 5. DIV1510N NATESAN 31. Date filed (Mor 32. egistrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Clayton Sterling Calloway May 12, 2010 $1:23p^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8540 Athol Road Mardela Springs Wicomico If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2□ F 47 07/20/1962 212-78-1093 Delaware **Director** Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits show 7 is marked other than "natural", or Items 23a or 28a-f shor traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2 No Director MD Wicomico Mardela Springs 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8540 Athol Road 21837 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐Yes 2 If Yes, Give 1 Never Married 2 Married 2K No altimore, Maryland 21215-0036 1 ☐Yes 2 ANo Specify þ Specify: White 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Je filed wh. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **Farmer** Grains & Truck Crops 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) d 2 should be fi th and Mental F 7 is marked oth William Thomas Calloway Jeanette Marie Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau Denise Green Calloway/spouse 8540 Athol Road, Mardela Springs, MD 21837 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Mardela Memorial Cem. May 16,2010 Mardela Springs,MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Short Funeral Home 13 E Grove St, Delmar, DE 21. Signature of Fundral Service Licensee ew Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one each line. Approximate Interval Between Onset and Death 23a. Part 1. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying executed Exami that initiated events resulting in death) Last and burial-t Due to (or as a consequence of) Box 68760. attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 1 □ Yes 2 No Division of Vital 1 ☐Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

To the P within 24 To the F

State Registrar

Passeri W) mi 31. Date filed (Month, 14

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Winterplace Registrar's Signatur

and manner stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
12:03 PM Physician/ ElizAbEth Christopher Mile Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NICOMICO PENINSULA REGIONAL MEDICAL Center 5. Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) If Under 8 Date of Birth 1 M 2 X F Months Days Hours Min (Month, Day, Year) Director 87 CARDLINE Usual Residence of Decedent ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Wicomico MARYLAND 1 Yes 2 No DALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral M): 11 MORRIS 21804 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic property. 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: BOCK 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic NONE 05 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ JEREMIAh Richard Worley Julia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chaistopher Salisburg HAZE 21801 ANE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State CEM 4 Donation 5 Other (Specify) 5-21-10 HEDRON Signature of Funeral Service Liven Name and Address of Facility STEWART 821 WESTRO (-UNERA) HOME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner 005 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi signed by the attending physician and does detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has!

The funeral director, page 2 is the funeral director, page 2 is the funeral director, page 2 is the funeral director. autopsy 2 No 1 Tyes __ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Certificate: To 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending injury work? 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month. Day, Year) 2010 44688 Gmil ed cause of death (Item 23a) (Type, Print) and address of person who complete

DHMH 17 Rev 7/2009

State

Registrar

KERRIGAN

19

100 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EVERETT THOMAS CONAWAY, SR. May 2/32 2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death 54/18644 NICONICO Year I If Under 24 Hr 8. Date of Birth (Month, Day, SEPT . 5 Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 □ F Months Hours 221-05-7895 Director 94 DELAWARE 1915 Usual Residence of Deceden 23a or 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director DELAWARE SUSSEX SEAFORD 1 ☐ Yes 2X No 10f. Zip Code 10g. Citizen of What Country? Funeral 6235 BELFAST ESTATES DRIVE 19973 AMERICA 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: WHITE 3 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) POULTRY EXECUTIVE OFFICER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JAMES ROLAND CONAWAY MARY LEE MORRIS 19a. Informant's Name/Relationship (Type, Print) 195. 2931 ing Address Grand Surples of Rupples to Number Githor Town, State, Zip Code) JANICE R. CONAWAY WIFE SEAFORD. DELAWARE 19973 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State injury or MAY 17,2010 COKESBURY, MD. 4 Donation 5 L ther (Specify) COKESBURY 21. Signature WATSON-YATES FUNERAL HOME, INC. SEAFORD. DELAWARE 19973 omplications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1. Enter the disease, shock, or heart failu nly one cause o Immediate Cause (Final Onset and Death Citysicient/ VRE Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Precumons Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Moderninal Wound attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Other (specify) Month Day Year Pregnant at time of death the g Unknown g 🗌 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 2 🗆 No 1 Yes 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA After this . Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 2 🗆 No after deat Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ only one 29b. Signature and title of certified 29c. License number 29d. Date signed (Month. Day, Year) 12010 168222 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 Mg SALISBURY

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Marv Elizabeth Cooper 2010 25 PM M May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wicomico Wicomico Nursing Home Salisbury If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9 Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🕇 F Months Hours Min. 06/27/1927 82 **Director** 230-28-2425 Virginia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 K Yes 2 No Hebron Wicomico Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21830 USA 113 W. Walnut Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. and Mental Hygiene. is marked other than "natural", or þ 1 Never Married 2 Married altimore, Maryland 21215-0036 Yes, Give 1 Yes 2 No Specify: Specify. white Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) food service 10 cook Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lena Mae (unknown) should be Robert Garrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 113 W. Walnut St., Hebron, MD 21830 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Paul H. Cooper/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Springhill Memory Gardens 1 X Burial 2 Cremation 3 Removal from State any injury or 5/18/2010 Hebron, MD 4. Donation 5 DOther (Specify) Signa vice Licensee 2HOTIOWAY Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 CFSP MOCO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mopths? Month Year Pregnant at time of death 5 Other (specify) 1 Yes 21 No cate has been signed by the a page 2 should be detached 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No. ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death
1 ☐ Natural
2 ☐ Accident
3 ☐ Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date, signed, (Month, Day, Year) 0 w

Smf

State Registrar 910 Easternshore Dr

ande

Salisbury MD 21804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Mahesha Thimmarayappa 31. Date filed (Month, Day, Year)

MAY 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 05 Physician/ 2010 William 2:16 Edward Carmichael Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number 8. Date of Birth (Month, Day, Year) Apr 2, 1930 9. Birthplace (State or Foreign Country) North Carolina If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours 1 🔀 M 2 🗆 F Yrs. Director 577-50-5648 80 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗆 Yes 2 🖵 No Virginia Fairfax Falls Church 10e. Street and Number 10g. Citizen of What Country? 6433 Lakeview Drive 22041 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 X Yes If Yes, Give 2 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed "natural" 3 Divorced 4 💆 Divorced Specify: Year or Dates 1951-53 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) id Mental Hygiene. marked other tha Analyst Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည McKinnon Carmichael Т. Julia Thompson or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>0</u>2 Health tem 27 John A. Carmichael/son 904 Village Gate Drive Mt. Airy, Maryland 21771 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Durial 2 🔀 Cremation 3 D Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Final Journey Crematory 5/19/2010 Woodbine, Maryland 21. Signature of Funeral Service Lie Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, M stimal M00957 Momen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shool, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATURY PAILURF Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner YPOGL Y(twi Sequentially list conditions, Examine Due to jor as a consequence on. if any, leading to immediate cause. Enter Underlying DEMENTIA attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Pregnant at time of death Dav Year 2 No cate has been signed by the page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ₩ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed? Yes 2 No 2 🗆 No 1 Tes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1 Tes 2 🏹 No ပ္ 1 Plnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Hospital or Attending 1- Natural 5 Pending Investigation 1 Yes 2 No Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) AZ MOHAMME U 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11/ AZIZ 251E. ANTIETAMST. SA Hagerstown

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carlson Richard Sinclair 2010 May 5:50 p. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Mary's Callaway <u>Hospice</u> House of St. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number 215-40-4167 (Month, Day, Yea 9-13-1941 1 X M 2 □ F Days Hours Min. Director Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at Director 10d. Inside City Limits 28a-f 1 Yes 2 XNo Maryland St. Mary's Mechanicsville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 29811 Joyce Way Funeral 20659 items 23a United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 X Married "natural", or þ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Accountant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Emportant: If item 27 is marked o any injuy or other traumatic evence. and Mental F မ George R. Carlson Mae A. Olson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Carlson/Wife 29811 Joyce Way, Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Crem. 5-24-2010 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., e of Funeral Seprice Licenses M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23 . Part 1. Eyle, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, the art failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death 3 montes Physician/ MEIASTATIC disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 5 485 & 2 mmtts Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iiniury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 🗌 No 1 Tyes Division of Vital 25. Was case referred to rhedical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Tes 2 🐼 No 은 4 Nursing Home 5 Residence 6 DOther (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Director: After 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

To the within 2 10 pme

State Registrar

31. Date filed (Month, Day, Year)

47412

M.D

KHAN, M.

erson who completed cause of death (Item 23a) (Type, Print)

only one) 29b. Signature and title of

30. Name and address

ST. MARY'S

188146

HOSPITAL

25500 POINT LOOKOUT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle 1 ast) 2. Date of Death Physician/ 2010 Month MAY GEORGE CLINTON DELBROOK 10 P 6:29 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, 1**x** M 2 □ F 89 Months Days Hours Min Mary Land 215-12-2393 Director Sept Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Walkersville 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 21793 53 Sherwood Drive death 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc þ 1 Never Married 2 XMarried 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white "natural", If Yes, Give Completed 3 Widowed 4 Divorced Specify Year or Dates traumatic event, the Medical 15 Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Boiler Plant operator Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Frank W. Delbrook Bertha Gertrude Witt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stella Delbrook – wife 53 Sherwood Drive, Walkersville, Maryland other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State ò XX Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place; injury (Glade Cemetery 4 Donation 5 Other (Specify) 5-14-2010 Walkersville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final -Physician/ ongestive disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 2 No 1 ☐ Yes 25. Was case referred to predical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes Hospital 2 No. Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending injury 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0064624 08/11/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shorma Sandeep Frederick, MD 21701 400 W

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

PARKANA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dennis Donahue John 12:17 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14603 Viewcrest Drive Cumberland Allegany Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) WI **Funeral** 8. Date of Birth 1 □_XM 2 □ F Days Month, Day Ye ^{ear)}19<u>25</u> Director 396-14-2166 84 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.
Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho important: If item 27 is marked of other than "natural", or item 25 a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 □ ¥es 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14603 Viewcrest Drive 21502 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No WW II 3 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) engineer ABL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ဂ John Donahue Stella (Biorklund) Donahue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 14603 Viewcrest Drive Mary Jane Donahue wife Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Scarpelli Funeral Home, P.A. 5/10/2010 4 ☐ Donation 5 ☐ Other (Specify) MD Cresaptown 21. Signature of Funeral Service Coensee 22. Name and Address of Furieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequen & of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner District for the a non-successive of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 110 Other: မှ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30 Name and address of person who completed cause ath (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Registrary Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene												
			1. Decedent's Name (First, Middle, Last) 2. Date of Death									
	Physicia Media		Gertrude	Madelin	е	Elliot	t	2. Date of Death May 14, 2010		3. Time of Death		
	Examir		4a. Facility Name (if not institution, give st 12024 Wishing Wel				r Location of Death berland		4c. County of Dea			
Ī	Funeral Director		Social Security Number 6. Sex	7. Age (In y	rs. last birthday) 5 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 08/25/1	9. B	irthplace (State or Foreign ountry) ryland		
			Usual Residence of Decedent					00/25/1	924 Ma	Tyland		
	yland -f sho ed at	ctor	10a. State 10b. County PA Bedfor		. City, Town or L	edford				10d. Inside City Limits		
	r 28a notifi	Director	10e. Street and Number	<u>u</u>						1 ☐ Yes 2 🖾 No		
	h with th rs 23a o nust be	Funeral	2373 Evitts Creek	Road		10f. Zip Code	5522	10	g. Citizen of What C USA	country?		
တ္က	ter deat or iten		11. Marital Status 1 ☐ Never Married 2 🌠 Married	 Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No 	13.	If Yes, specify Cuba	ispanic Origin? (Spe an, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whi			
8	urs af tural" al Exa	Completed by	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.		1 ☐ Yes 2 💢 No	Specify:		Specify:	White		
15-	72 ho n "na nedic	nple	15. Decedent's Edu (Specify only highest grade		(Give	dent's Usual Occup kind of work done o OO NOT use retired)	ation during most of worki	ng 16	6b. Kind of Business Industry			
212	within giene. er tha	S	Elementary/Seconday (0-12)	College (1-4 or 5+)		egistered	Nurse		Public Sc	ablic Schools		
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last) John Edwar	d Merb	augh		18. Mother's Name Catherir	e (First, Middle, Mai	^{iden Surname)} lizabeth	Mansfield		
Mary	should n and Me	6 33	19a. Informant's Name/Relationship (Type William D. Elliott		19b. Mail	ng Address <i>(Street a</i> 3 Evitts	and Number or Rura Creek Roa	I Route Number, Ci	ity or Town, State, Z	ip Code) 3522		
ē,	and Heal		20a. Method of Disposition	20	b. Place of Disp	osition (Name of			Oc. Location - City o			
timo	permit. Page 1: Department of I Important: If it any injury or of		1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Jnion Ce		05/17		Centervil			
e E	permi Depar Impor any ir	6 3	21. Signatury of Funeral Service Acensee	2008			ss of Facility Ada Ir Street,			Home, P.A. 21502		
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate										Approximate Interval Between		
- 4	Immediate Cause (Final disease or condition a. Coronary Artery Disease									Onset and Death 15 years		
	Examiner		Sequentially list conditions, b.	Due to (or as a cons	sequence of):							
	ted Insit	dical Examiner	if any, leading to immediate Cause Chief United Straining Cause (Disease or iinjury	sequence of):								
	cate be executed physician and s the burial-transit	al Exa	that initiated events c. resulting in death) Last	Due to (or as a cons	sequence of):	-				_		
3	physic physic the b	0	d.									
000	certific nding use as	Z/	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pre					23d. Date of de	aliven		
DOX.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown		Ectopic pregnanc Other (specify)	у		Month	Day Year		
7. O	s that th gned by be detac	by P	Part II. Other significant conditions cont		resulting in the o	underlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	o the cause of death?		
S	equire een si ould	Alzheimer's Disease 1 Yes 2 No 3 Probably 4 Unk										
Records,	he law r te has b age 2 sl	Lupus 24a. Was an autopsy findings avail prior to completion of cause death?										
VII a	vian; T ertifica ctor, p		25. Was case referred to medical examiner?			26. Pla	ace of Death (Check			s 2 🗆 No		
5	Physic this of al dire	욘	1 ☐ Yes 2 🗓 No	spital:				me 5 Residenc	e 6 🕅 Other (Spec	Daughter's Residence		
SIOII OI	ding F th. After funera	cate	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work		8d. Describe how i	njury occurred			
NISIC NISIC	or Atter fter dea irector n by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	home, farm, str	eet, factory, office		t and Number or Ru tate)	d Number or Rural Route Number,				
5	spital of ours a neral D		29a. Certifier 1 X Certifying Physici	an: To the best of my kno	owledge death	occured at the time	date and place, and			etad		
	the Ho thin 24 the the Fur mpleted	Medical	only one) 3 Gertifying Nurse F	 On the basis of examina 	ition and/or inves	tigation, in my opinio death occurred at the	n, death occurred at time, date and place	the time, date and p	lace, and due to the	cause(s) and manner stated.		
			29b. Signature and title of certifier	///	1//	29c. License D35		29d	Date signed (Monta). May 14			
	2	ł	30. Name and address of person who com	pleted cause of death (It	em 23a) (Type, F	Print)		land MD	21502			
	nds		Thomas E. Chapper 131. Date files (North Par Year)	A Pagistraria Oig	matura A		e, Cumber	rand, MD	Z 130Z			
	Stat Registra	r	31. Date film Worth Pay Year 2010	Rem B.	parke	!						

				riease	State of						Mental Hy			10.	
		-	For State Registrar		Oldio o	war yrar			e of De			Reg. N	7111	0	17523
			Decedent's Name (First,	Middle, Las	st)						2. Date of De	eath		ear	3. Time of Death
	Physicia Medio		Doris V. F	Month May					L8 _20)10	4:00 A ^M				
Œ	Examir	er	4a. Facility Name (if not ins			per)				ocation of Deat	า		c. County of I	Death	
	Funeral	-	Ivy Manor 5. Social Security Number	last birthday)	If Unde	r 1 Year	t City If Under 24 Hrs	8. Date of Bir	th	Ioward 9		ace (State or Foreign			
	Director		149-26-633 Usual Residence of Deced	7	□ M 2 ¾ F		77 Yrs.	Months	Days	Hours Min.	July 2	y, Year)	932	Counti	NJ
	and show	ō		County		10c. Ci	ty, Town or Lo	cation						10	d. Inside City Limits
	Maryl 28a-f otifie	irect	MD Ho	ward		E11	icott (City							1 Yes 2 XNo
	th the	al D	10e. Street and Number						p Code				itizen of Wha	t Count	ry?
	ath wii	uner	2817 Monto	lair I	12. Was Deced	ent Ever in U.	S. 13. V		1043	panic Origin? (S	pecify Yes or No-	US	14. Race - /	America	n Indian.
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	1 Never Married 2 3 XWidowed 4 D		Armed Ford 1 Yes If Yes, Give Year or Dat	ces? 2 🖾 No			cify Cuban, 2 🛛 No		oecify Yes or No- o Rican, etc.)		Black, \	Vhite, e	tc.
Maryland 21215-0036	י 72 hou ו. an "natu Medical	mplet			ducation ade co <i>mpleted)</i> College (1-4	1 or 5+)	(Give i	kind of wo	t's Usual Occupation d of work done during most of working VOT use retired)				b. Kind of Business Industry		
212	withir giene ier tha	ပိ	12	(0-12)	College (1-4		Secre	etary	,			Tr	caining	, Fa	cility
nd	e filed Ital Hy ed oth even	To Be	17. Father's Name (First, M						- 1		ne (First, Middle,		Sumame)		
ryka	d Mer d Mer mark matic		George D		ime Print)		10h Mailir	a Addros			Albright		or Town State	Zin C	odel
	d 2 shoalth an 27 is or trau		David Fras								d., Wood				
Baltimore,	of Head of Hea		20a. Method of Disposition		Demouslifuem 6		Place of Dispo cemetery, cren	sition (Na	me of other place)		Date	20c.	Location - Cit	y or Tov	vn, State
ij	Page ment tant: I		4 Donation 5 0	Other (Specif	fy)	La	keview	Mem.	Park	05/2	4/2010		nnamir		
Bal	permit Depar Impor any in once.		21. Signature of Funeral S	rvice Licens	see	M0141									ly FH, Inc MD 21043
			23a. Part 1. Enter the dise	ease, or comp	plications that ca	used the deat							000 01	T	Approximate
-	Ph_sician/		shock, or heart failure Immediate Cause (Final disease or condition	e. List only o				. 6	6:000						Interval Between Onset and Death
	Medical Examiner		resulting in death)		a. Due to (o	r as a conseq	uence of):) ''	0105	12					
1	Examiner	-e	Sequentially list condition	s,	b. — Due to (e			_	-					\perp	
	ed set	min	Sequentially list condition if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	te 🐇	Due to (o	r as a conseq	uence oi):								
	be executed sician and burial-transit	cal Examiner	that initiated events resulting in death) Last		C. Due to (o	r as a conseq	uence of):								
90	te be exe nysician he burial			-	d									+-	
9289	ertifica ding ph	/Me	IF FEMALE:		23c. If yes, outc	ome of predna	ancv						001.0	<u> </u>	
Вох	To the Hospital or Attending Physician: The law requires that the death certificate knithin 24 hours after death. On the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the knither than the funeral director, page 2 should be detached for use as the knither than the funeral director.	Physician/Medi	23b. Was decedent pregna in the past 12 months 1 Yes 2 No 9 Unknown	int	1 Live B	irth 2 🗀 Fetant at time of	al death 3	Ectopic Other (s					23d. Date o Month		y Day Year
P.O.	es that the des signed by the s be detached f	y Ph	Part II. Other significant of	onditions o	ontributing to de	ath but not res	sulting in the u	nderlying	cause give	n in Part I.	23e. Did t	obacco	use contribu	te to the	cause of death?
JS,	v requires t been sign should be	Completed by									1 🗆	Yes 2	No 3	Prob	ably 4 🗆 Unknown
Records,	law rec has bee	plet									24a. Was auto	psy	prio	r to con	sy findings available inpletion of cause of
Re	The la	Con									1 🗆 Yes	ormed?			2 □ No
ita	hysician: The lav nis certificate ha: I director, page 2	Be	25. Was case referred to m examiner? 1 Yes 2 No		Hospital:				Other	e of Death (Che			74		Assisted
of Vital	ding Physi th. After this c funeral dire	و: ا	27. Manner of Death		28a. Date o	finjury	ER/Outpatier 28b. Time of		OA 28c. Injury a	4 L Nursing F	forme 5 Resi		•	pecify)	Living
on	anding sath. or: Afte	ficat	2 Accident	Pending Investigation	1	, Day, Year)	injury	М	work?	es 2 🗆 No					
The property of the part of Death 28a. Date of injury 28b. Time of injury 28b. Tim									28f. Location (Street and Number or Rural Route Number, City or Town, State)						
_	Hospita 24 hours Funera eted fille	Medical	(Check 2 Me	dical Exami	sician: To the be iner: On the basis se Practioner: To	of examinatio	n and/or invest	igation, in	my opinion,	death occurred	at the time, date a	and plac	e, and due to	the caus	se(s) and manner stated.
	To the within To the compl	2	only one) 3 L Ce 29b. Signature and title of	/-/				290	. License n	umber		29d. D	ate signed (M	onth, D	ay, Year)
)	4 and	MD				D 47	447		Ma	14 18	201	0
	6		30. Name and address of p	person who	completed cause	of death (Iten	23a) (Type, P	rint)	. 100		-mbia,	UA	,	0	
	Sta	e	Hnyl Lazr 31. Date filed (Month, Day,	Year)	32. ₽€	gistrar's Signa	ture,) 1	e 103	. 01	- mpia	MIC	ryland		
	Registr:		MAY	202	MINI A	- 400 -	A Sa	B. Ke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cornelia Belle Furlow Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Western MD Regional Medical Center Cumberland 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Months Days Hours Country) Director 173-03-2063 93 01/11/1917 Pennsvlvania Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11726 Bedford Road, NE 21502 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Hygiene. other than "natural", 1 ☐ Yes 2 X No Specify: 3 😾 Widowed 4 🗆 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other ti 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic v Harvey Minnich Margie Naugle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12800 Woodcock Hollow Rd, Mt. Savage, MD Janet Nicol / Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 05/12/2010 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD Liunsture of Funeral Score Li 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 1)1600 Immediate Cause (Final Coron Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a const quence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Pregnant at time of death Month 2 No signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy page performed? Yes 2 No 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 1 \square Yes 2/ No Other: 은 after death.

Director: After this of 1 Nnpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred .14 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide pleted filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature ar of certifier 29d. Date signed (Month, Day, Year) May 12, 1)0033280 2010 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nds

Registrar DHMH 17 Rev 7/2009 Sunil K. Gupta,

12 2010

31. Date filed (Month, Day, Year,

M.D.,

32. Registrar's Signature

625 Kent Avenue, Cumberland, MD

21502

Please Type or Print in Black Indelible Ink. Finyire All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Katherine Azalea Bowen Griffith May 13, Year 2010 5:30 рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARRISON HOUSE SENIOR LIVING SNOW HILL WORCESTER 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 ื F Days Hours Min (Month, Day, Year) 2/05/1919 Washington, 90 Director 578-22-9193 Usual Residence of Decedent 28a-f shov 10a. State 10b. County traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Numbe 10f. Zip Code 5 10g. Citizen of What Country? 23a (Funeral 6324 Feather Heights Drive 21801 USA tems within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give "natural", or i Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) social worker permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event ** Wicomico County and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leonard Lee Bowen Sr. Marie Gessford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6324 Feather Heights Dr., Salisbury, MD 21801 William R. Griffith II/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Buriał 2 XI Cremation 3 Removal from State Depation 5 Other (Specify) 5/15/2010 Salisbury, MD Salisbury Crematory Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 domosor CFSP 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) pe Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 2 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred **X**Natural 5 Pending injury Accident 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signat 29c. License number 29d. Date signed (Month, Day, Year) 054422 BAR 30 Name and address of person who completed cause of death (Item 28a) (Type, Print) MD Ket ocon 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marion Toulmin Gaines, III 5-23-2010 Day 4:15P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Charlotte Hall Veterans Home Charlotte Hall If Under 1 Year If Under 24 Hrs i. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 3-26-1923 F18rida Director 264-28-6800 87 Usual Residence of Decedent should be filed within /z nours and Mental Hygiene.
I is marked other than "natural", or items 23a or 28a-f show reaumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits Director Kensington 1 Yes 2 No Maryland Montgomery 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 3906 Spruell Court 20895 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? 1

Yes 2

No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Radio Announcer Broadcasting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marion Howie permit. Page 1 and 2 should be Department of Health and Menl Important: If item 27 is marke any injury or other traumatic once. Marion Gaines, II traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3906 Spruell Ct., Kensington, MD 20895 Stan Gaines/Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 X Cremation 3 Removal from State 5-26-2010 Charlotte Hall, MD Brinsfield-Echols Crem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield-Echols F.H., F.A., Si mature di ane al dervice Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 4 ☐ Pregnant at time of death g ☐ Unknown 2 No ate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HORTIC ANEURYSM 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 ☐ Yes 2 ☐ No 2 D N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2\JN0 은 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 14 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0067788 5.24.2010 wheel

Seme

DHMH 17 Rev 7/2009

State Registrar LEENA

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAO KODALT, Charlotte Hall, MD 20622

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** TRUSS Agnes 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles pita STA If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 X F Days Hours Min. 214-28-9626 70 20 Director MARYland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 XYes 2 No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 454 Funeral 20601 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14 Race - American Indian 11. Marital Status Black, White, etc 1 ☐ Yes 2 K If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify \$ Specify: 3 X Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omestic 12 tomeivaker Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, If once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thaddeus ဂ္ Ashinston Ura Geneve 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20601 Gross Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 Removal from State MI 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice Mame and Address of Facility MI 1589 20608 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Fibrillation Ventricular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Myocardige Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Heart Hiscane Hypertensice Due to for as a consequence of): burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) ed by the a 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 **N**No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 2

State Registrar

completely

Medical

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SATISIT SUMANI, M.D. 10 St. Poutrick & Drive, Suite 208, worlderf, MD20603 SATISH 31. Date filed (Month, Day, Year) 32. Redistrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

35275

29d. Date signed (Month, Day, Year)

.10

- 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 4 per FH G904 6/4/10 dk

State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9'38PM Harris Jane Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany 14136 Louise Drive Cresaptown Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. S2925e24×10387 7. Age (In yrs. last birthday) **Funeral** 1 M 2 DF Feb 14 *″19<u>28</u> 212-24-2387 82 Director 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27: is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State Director Allegany MD Cresaptown 1 □xYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 14136 Louise Drive 21502 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ۾ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates white Completed 3 XVidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Elva Edna (Grant) Stottlemyer John Howard Stottlemyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21502 14136 Louise Drive Andrew Harris son Cresaptown 20b. Place of Disposition (Name of cemetery, crematory or other place)
Rocky Gap Veterans Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6/1/2010 Flintstone MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. P f 1. Enter the rise s..., r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Metastanc endonetri disease or condition MONH Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examiner if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) tor: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atrial 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 si prior to completion of cause of death? autopsy performed' 2 1 No 2 2 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes မှု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000599 6-1-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ETON DRIVE CLIMPERLAND, MD 21502 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death ent's Name (First, Middle, Last) Date of Death Physician/ Medical acility Name (if not institution Examiner Town or Location of Death 1 Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 M Months Hours Min. Sept. 30. 1940 Washington, DC 213-38-4906 Director 69 Usual Residence of Decedent "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Severn 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 8234 WB & A Road 21144 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify: 3 ☐ Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) C&P Telephone Company Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert LeRoy Durst, Sr. Mary Huffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8234 WB & A Road Severn, Maryland 21144 Bonnie Slye -daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Columbia Memorial Park 1 X Burial 2 Cremation 3 Removal from State 6/3/2010 Clarksville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Donald V. Borgwardt Funeral Home, PA on 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Vears Immediate Cause (Final Priysician. Metastatic Bladder Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated as or injury Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month been signed by the should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 De Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed After this certificate funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🖸 No Other: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work Accident 1 Tyes 2 🗌 No Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 124 hours after of Evaneral Direct 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined filled in I City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the pasts or examination and/or investigation, in his opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29b. Signature and title of certific 29c. License numbe 29d. Date signed (Month, Day, Year) D38509 June 1, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas Koutrelakos, M.D. 10710 Charter Drive, #G020 Columbia, Maryland 21044

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

park

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Walter Detloff Hoffman Jr 2:48 May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) 1 ★ M 2 🗆 F Months Hours Min. Director 231-42-7313 /29/1935 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "nature!" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD Frederick Middletown 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 Broad St. Apt. E-52 21769 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 XYes 2 No. 1957 -Black, White, etc. þ 1 Never Married 2 Married 1 XYes If Yes, Give Specify: White 3 Widowed Divorced 1 ☐ Yes 2 X No Specify: Completed 1960 Year or Dates 15, Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) real estate Elementary/Seconday (0-12) College (1-4 or 5+) president Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Detloff Hoffman Sr. Edna Mae Christian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Maddox Representative)POB 68. Braddock Hgts. MD 21714 20a. Method of Disposition 20b. Place of Disposition (Name of Penelm Senator) or other place) 20c. Location - City or Town, State Date 1 ⚠ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/24/2010 Newport News, VA Memorial Park Sign ture f Fun a al Jervice 22. Name and Address of Facility
Donald B. Thompson Funeral Home Middletown, MD 2 a. Part 1. Enter the disease, or complic ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one Interval Between Imme liate ause (Final disease ondition resulting in death) Onset and Death ₹hysician/ condion 25 unter dises Hypertungive atheroscherotic Medical Due to (or as a consequence of) Examiner GR-JUS HTN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 ☐ Other (specify) Month Day Year ed by the a 9 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed I completed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗷 No မြ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 1 ANatural injury 5 Pending Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W 05/17/10 052056

State Registrar DHMH 17 Rev 7/2009 Albert C

31. Date filed (Month, Day, Year)

400 W 7th St

32. Registrar's Signature

Frederick, mo 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Villarosa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harry 2010 Medical 10:45 a M May 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 21250 Point Lookout Road Callaway St. Mary's **Funeral** Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 **X**XM 2 □ F Months Days Min. Hours 05/01/1940 New Jersey Director 148-30-5255 70 Usual Residence of Decedent 28a-f show and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County Director 10c. City. Town or Location 10d. Inside City Limits ems 23a or 28a-f sh الله عند 23a or 28a-f 1 ☐ Yes 2 🛣 No <u>Maryland</u> St. Mary's Callaway 10f. Zip Code 10g. Citizen of What Country? Funeral 21250 Point Lookout Road 20620 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? 1

Yes 2 □ No ō Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 "natural", 3 Divorced If Yes, Give 1 ☐ Yes 2X No Specify: Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 Ith and Mental Hygie 27 is marked other r traumatic event, th Mechanic HVAC Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harry Horn Virginia Herman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Barbara Horn/Spouse 21250 Point Lookout Rd., Callaway, MD 20620 20a. Method of Disposition Page 1 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Grd. 05/24/2010 Leonardtown, MD Si Pheral Serv Edward N. B 21. Si 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 Brinsfield. M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ CANCER ? ROSTATE Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any hading to have distincted ease. Enter Underlying Cause (Disease or linjury that initiated events Dile to (or as a consequence or) Exami that the death certificate be executed and -tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the burla Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Dav Year Yes 2 No 4 ☐ Pregnant : 9 ☐ Unknown detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 23e. Did tobacco use contribute to the cause of death? PVLMONARY or Attending Physician: The law requires OBSTONCTIVE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ◯ Unknown MYREATENSON Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an autopsy Yes 2. No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending injury work' within 24 hours after death. To the Funeral Director: A Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56096 5-20-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 24035 three Notch Rd., Hollywood, MD 20636 Rajbinder S. Gill, M.D. 31. Date filed (Month, Day, Year) State egistrar's Signature

DHMH 17 Rev 7/2009

Registrar

MAY 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HETLER Physician/ Month 2010 AULINE 17233AM Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WNOSH Ryin 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 282-14-2757 94 Director OH Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Berlin 1 Tes 2 No MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21811 USA 1 Meadow St. Unit 312 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: white 3 ™ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Lottie Vay Kurtz Hoyt Saunders Shryock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1030 Buena Rd., Lake Forrest, IL 60045 Dennis Hetler / son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/1/2010 Mansfield, OH Mansfield Cem. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signatur of Funeral Service Licensee 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between nset and Death Physician/ 01 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death to the Funeral Director. After this certificate has been signed by the accompleted filled in by the funeral director, page 2 should be detached 1 L Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? None Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1/11/10 ပု 1 Yes 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral D Medical 29a. Certifie Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gertiying Nurse Practionen To the basis of my bounday, death continued at the time, date and place, and due to the general state. (Check the D0050826 M) 30. Name and address of person who completed cause of death (Item 23a) (Typg, Print)

Na 7- inn K 9 nin La 9733 He Maway Dr Be Gn, MD BAID 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

12-H-28

01-11-5

Desth

0

Ó

Tot

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 05 10 PM 2010 Della В. Johnson Medical 4a. Facility Name fif not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death Wicomico lisbur 050ice)a If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**X** F Months Days Hours Min (Month, Day, Year) -28-1920 90 Director 215-14-3200 Usual Residence of Decedent show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 X Yes 2 No Snow Hill MD Worcester 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 501 Maple Avenue 21863 USA items (death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ō Completed by 1 Never Married 2 Married эегтіt. Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural". Specify:Black 3 Widowed 4 Divorced Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) nd Mental Hygiene. marked other tha Custodian Worcester County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ <u>Isaac Beckett</u> Hattie Collins f Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearl Purnell/Niece <u> 106 Maple Court 1. Snow Hill. MD 21863</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of cemetery, crematory or other place) 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Bonation 5 Other (Specify) 5-19-2010 Pocomoke, MD Shiloh UMC Cem Signature of Funeral Service License 22. Name and Address of Facility Bennie Smith 917 W. Isabella St Salisbury, MD 21801 Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ DEMEN disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Other (specify) Month Dav Year Pregnant at time of death 1 Yes 9 I Haknowa Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director; After this certificate has autopsy 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence filled in by the funeral Certificate: 27. Manner of Death Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury iniury 5 Pending work? 2 Accident 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated captifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0058410 out 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 30

DHMH 17 Rev 7/2009

State Registrar

Ohnson

egistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 25 per phys. G906 8/19/10 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day - Marie **Physician** KOISS man 10: 25 PM ves 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days 1 X M 2 □ F Yrs 227-19-8837 61 Director 08/01/1948 Benin Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 X No Directo Examiner must be notified Maryland Montgomery Potomac 10e. Street and Number 10g, Citizen of What Country? 10f. Zip-Code ō items 23a 11216 Broad Green Drive Cote d'Ivoire 20854 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🕱 Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify \$ Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ IMF Administrator/Financier World Bank 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, 17. Father's Name (First Middle Last) Be Marie Bernard Koissy Therese Amani မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 g Department of Health ar Important: If item 27 is any injury or other trau once. 11216 Broad Green Drive, Potomac, Maryland 20854 Eulalie G. Koissy - Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 💢 Removal from State Ukn 4 ☐ Donation 5 ☐ Other (Specify) Ukn Bengassou, Ivory Coast 21. Signatu of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final heratoce lular
Du to (or as a consequence of): **Physician** carcinoma disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dividu (unas a nunsilorementi) The law requires that the death certificate be executed physician and as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical as a guilpu IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death
9 Unknown Month 5 Other (specify) igned by the at I be detached for ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 1 Yes 2 No 2 No Yes Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 28a. Date of Injury this funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation After death. 1 Yes 2 No 2 Accident pirector; filled in by the 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide City or Town, State) 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number RES 000 May 11 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 hristian Gocke 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State Backer Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Catherine Virginia Klavuhn 12:50 P Medical May 17 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Cresaptown 14716 Main Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Funeral Hours Min. 1 ☐ M 2 🕅 F Country) Marvland 89 Director 215-16-4477 05/04/1921 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Tyes 2 No Allegany Cresaptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14716 Main Street 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White etc. þ 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates. 3 😾 Widowed 4 🗌 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) State Government 12 Licensed Practical Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harry Troutman Marie Fontan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) mit. Page 1 and 2 sh partment of Health a portant: If item 27 is y injury or other trau 14716 Main Street, Cresaptown, MD Debra Laco / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 05/18/2010 Cumberland, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ OLON disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consecution to our that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 5 Other (specify) the a 1 ☐ Yes ∠ p 9 ☐ Unknown a T Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by DISENSE ARKINSONS 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed this certificate 2 **X**No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 2 🔼 No 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 18, 2010 D33417

Registrar DHMH 17 Rev 7/2009

State

n ls

Box 68760

P.O.

Records,

Division of Vital

1068 National Highway, LaVale, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

James R. Moen, M.D.,

18 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ KIMMEL QUINTEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5. Social Security 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, 1 M M 2 🗆 F Country) 175-30-096 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location . If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director BEDFORD HYNOMAN 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5545 LANDIS USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: Specify: WHITE Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CONSTRUCTION DRIVER TRUCK Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ GEORGE KIMMEL CAMPBELL NELLIE M. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a HUNDMAN RD HUNDMAN PA 15545 4351 KIMMEL SOIN 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 5-13-2010 GLENCOE 4 Donation 5 Other (Specify) MT. LEBANON 22. Name and Address of Facility HARVEY H. ZEIGLER FUNERAL Signature of Funeral Service Licenses HOME INC 169 Clarence St HYNOMAN PA1554S 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final corebrovascul Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician all s the burial-t Physician/Medical attending pl IF FEMALE: , asn yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Dav Year 1 Yes 2 ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Certificate: To Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1/ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 924 Setu MANYCAMI Drive 21502 umberland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 13 2010 Darker Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month May 21°, 2010 1:30 a Opa1 Irene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's St. Mary's Nursing Center Leonardtown 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1 ☐ M 2🛣 F Indiana 09/20/1914 Director 95 378-14-6120 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merital Hygiene.

Important: If fired 71 is marked other than "nature." 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2X No Maryland St. Mary's Mechanicsville 10e. Street and Number 10g. Citizen of What Country? Funeral 42366 Manor Drive 20659 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc 1 ☐ Yes 2 🛣 No If Yes, Give ģ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bertha Burleau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne J. Pelz/Daughter 42366 Manor Dr., Mechanicsville, MD 20659 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols 05/22/2010 Charlotte Hall, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. dward N. B 22955 Hollywood Rd., Leonardtown, MD 20650 Brinsfield, J€ ₩00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) 110 Medical Die to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has be funeral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes |은 1 Inpatient 2 I ER/Outpatient 3 I DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined within 24 hours a

To the Funeral C Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signa

2 Rme

Registrar
DHMH 17 Rev 7/2009

State

25365 Point Lookout Rd., Leonardtown, MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. Boyd, II, M.D.

MAY 2 5 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 18^{Day} Irving 01iver Kemp 2010 5:10 pM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6303 Arrowhead Drive Hurlock 5 4 1 Dorchester 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Min. Hours April Day 22,1949 Maryland 217-52-0498 Director Vre Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified 1 🗆 Yes 2 🗀 No 23a or 28a-f MD Dorchester Hurlock 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Page 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a ury or other traumatic event, the Medical Examiner must b 6303 Arrowhead Drive 21643 USA Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? by Black, White, etc. Baltimore, Maryland 21215-0036 1 Never Married 2 X Married If Yes Give 1 Yes 2 X No Specify: white Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) painter home improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Irving Kemp Audrey Smith 19a. Informant's Name/Relationship (Type, Print) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6303 Arrowhead Drive, Hurlock, MD 21643 Peggie Kemp wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department c Important: If any injury or 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) East New Market Cem. 5/21/10 East New Market, MD 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death lung carcinoma Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery signed by the atten I be detached for u 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law autopsy performed? Yes 2 2 No After this certificate has 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes Other: 2 □**x**No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural injury 5 Pending death. 1 Yes 2 No Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 069234

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Yea

503 BYRN

STREET

CAMPRIDGE, MO 21613

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Month Year Irene G. Liggett 25, [™]2010 2:40А. м Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Montgomery Casey House Hospice Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months Dec. 23, 1922 1 □ M 2 😾 F Hours 87 Pennsylvania **Director** 578-44-3597 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the May/and Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Greenbelt X Yes 2 ☐ No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14 D Ridge Road 20770 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 Yes 2 No 1 Never Married 2 Married Black, White, etc. Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1944-1945 1 ☐ Yes 2√2 No Specify: 3 🗆 Widowed 4 🗆 Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Josephine (unk) Edward Zaleski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert T. Liggett -husband 14 D Ridge Road Greenbelt, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gate of Heaven Cemetery 5/28/2010 SilverSpring, Maryland 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Dönard Vie Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 Maralel 0.130 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Chronic Obstructive Pulmonary Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify)☐ in the past 12 months?
1 ☐ Yes 2 🗓 No Month Year the þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Congestive Heart Failure Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💹 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

Yes 2 No certificate 2 X No 1 🗌 Yes 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Hospital 2 📝 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) hospice eral Director: After this filled in by the funeral di 27. Magner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner of the basis of examination arrows investigation, in my spanish, date and place, and due to the cause(s) and manner as stated. only one Tol 29b. Signature and title of certifier 29c. License number

DHMH 17 Rev 7/2009

State Registrar

ORIGINAL

Nicole Christenson, CRNP-F 6001 Muncaster Mill Road Rockville, Maryland 20855

Willeson Club-t

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

RN 120698

29d. Date signed (Month, Day, Year)

May 25, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			for State Amended item#20b, WCHD,	SLU,5.2	Department of He ²⁷ Certificate of De	ealth and Men eath	, ,	2010	17540		
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	,		2. [Date of Death		3. Time of Death		
	Medic	cal		Lo			May , 1	6, 2010	6:35 P-M.		
and the same	Examin	ier		ab. Cent							
	Funeral Director		5. Social Security Number 6. Sex 7. Ag		rthday) If Under 1 Year	If Under 24 Hrs. 8. [Hours Min. (Month, Day, Year	9. Bii	thplace (State or Foreign buntry)		
		L	Usual Residence of Decedent		un or Logation		945+, 4,	19391 100	any land		
	arylan ta-f sh ified a	Director							10d. Inside City Limits 1 Yes 2 □ No		
	the M a or 28 be not	ä	10e. Street and Number	~	10f. Zip Code		10g.	Citizen of What Co			
	th with ms 23, must	Funeral	10000	Rd.				U.S.	A		
9	e filed within 72 hours after death with the Maryland Hygiene. and Hygiene. and other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	Armed Forces? 1 □ Never Married 2 Married 1 □ Yes 2 🖼		If Yes, specify Cuban,	Mexican, Puerto Ricar	es or No- n, etc.)				
21215-0036	ours af tural", al Exa	ted	3 Wildowed 4 Divorced Year or Dates.					Specify: B	lack		
215-	היי 72 hc an "na Medic	mp[e	As Pacific Name in Proc Institution, give street and number) As Pacific Name in Proc Institution, give street and number) As Pacific Name in Proc Institution, give street and number) As Pacific Name in Proc Institution, give street and number) As Pacific Name in Proc Institution, give street and number) As Pacific Name in Proc Institution, give street and number of Name in Pacific Name in P	Industry							
21	ed within Hygiene. other tha	Φ	10th grade		nvivonmental S	vervices Aid	de Pe	ninsula Re	g. Med. Centra		
Maryland	be filed ental Hyg ked oth ic event,	To B			1			•			
ary	should be fil and Mental is marked aumatic ev				b. Mailing Address (Street and				o Code)		
ē,	and 2 sl Health a tem 27 i				4306 Tower		-		21863		
mor	age 1 aent of H		1 🛱 Burial 2 🗌 Cremation 3 🗌 Removal from State	20b. Place of cemetr	of Disposition <i>(Name of</i> ery, crematory or other place) ams A.M.E. Cem	Date petery					
Baltimore,	permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.			Wallach		of Facility Lewi	S No V	Natson	F.H. PA		
	20200		23a. Part 1. Enter the disease, or complications that caused	the death. Do		such as cardiac or resp	Salisbur	y.md,	Approximate		
Shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition CARCINOMA OF LUNG											
	Medical Examiner		resulting in death) Due to (or as a	a consequence	of):						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last								
	ecuted and I-transi	Examiner									
0	icate be executed physician and s the burial-transit	edical	d								
3876	irtificat ling ph e as th			,							
XOX	eath certifica attending p	ician	in the past 12 months? 1 Use Birth 1 Pregnant a	2 Fetal deat					livery Day Year		
О	it the d by the	Physician/M	9 ☐ Unknown ` 9 ☐ Ulikilowii								
Division of Vital Records, P.O. Box 68760	irres tha signec Id be de	þ	Part II. Other significant conditions contributing to death b	at not resulting	in the underlying cause given	in Part I.					
Sord	aw requas beer 2 shou	Completed				2			topsy findings available		
Rec	sician; The law certificate has birector, page 2 s						performed?		completion of cause of		
/ital	sician s certifi lirector	To Be	examiner?		Otherm						
fo i	ng Pny fter this ineral c		27. Manner of Death 28a, Date of injur	y 28b.	Time of 28c. Injury at				ify)		
ion	ttendii death. ttor: Af	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be		M 1 ☐ Yes						
	ar or A s after al Direct				irm, street, factory, office				al Route Number,		
_ :	or the rospital or Attending Prystolan; The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 \square Medical Examiner: On the basis of ex	kamination and/o	or investigation, in my opinion, c	death occurred at the tir	me date and place	e and due to the o	ause(s) and manner stated		
:	vithin To the compli	Σ	29b. Signature and title of certifiar	sest of my know	29c. License nu	mber	29d. D	ate signed (Month	, Day, Year)		
	0					2172	5	118/2010)		
-	2 m		CARDAD D CATILAL MI) 16	004 MA	PRICET ST POC	LOMOKE CI	4 MD	2(851.			
ı	State Registra	e r	31. Date filed (Month, Day, Year) 32. Figistra MAY 19 2010 32. Figistra	r's Signature	pare						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lindner Lou Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WMHS-RMC Allegany Cumberland Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funera Birthpies Country) MD 1 🗆 M 2 🗆 F (Month, Day, Jun 5. Director 216-22-6946 82 Usual Residence of Deceden item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Frostburg 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Kaylor Circle 21532 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. Completed 3 XWidowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) registered nurse nursing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ဂ္ Baxter C. Harsh Bessie (Crable) Harsh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code MD 21784 Michael Lindner 6471 Monroe Avenue Eldersburg son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Davis Memorial Cemetery 5/14/2010 Cumberland MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part Enter the disease or complications that caused shock, or heart failure. List only one cause on each line Approximate shock, or heart failu Immediate Cause (Final disease or condition Interval Between PNEUMONIA Onset and Death Physician/ resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 1 No Month Day Year 1 Yes 24 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 U Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 U Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 7 Geolhi 10 D2690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARJIT SIDHU .925 BIS SH ROAD CUMPEPL m.D 31. Date filed (Month, Day, Year)

MAY 1 4 2010 State

DHMH 17 Rev 7/2009

Registrar

P.O. Box 68760

Records,

Division of Vital

Barke

10-04018 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Christopher Kyle Lindner State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 26, 2010 Medical Examiner Christopher Kyle Lindner 1044 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4630 Egypt Road Cambridge Dorchester 6. Sex **Funeral** 5 Social Security Number 216-27-0828 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Director Days Hours 02822 F 24 1 X M 25. 1985 Maryland Usual Residence of Decedent any 10a, State 10c. City, Town or Location 10d. Inside City Limits MD Dorchester Cambridge or items 23a or 28a-f show must be notified at once. 1 Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 4630 Egypt Road 21613 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2X No Yes white 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: ₫ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed permit. Pages 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 chef restaurant 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Sumame) William Jefferson Lindner Be Jennifer Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt: If item 27 is other traumat Jennifer Langkammerer mother 6391 Statum Road, Preston, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dorchester Mem. Park 5/29/10 Cambridge, MD 4 Donation 5 Other Specify: Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Physician Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease Asphyxia Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and I be detached for use as the bunal - transit Physician/Medical #5 per fh,g905,07/09/2010dhb X UNPENDED the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. .28a-f.per ME g904 6/18/10 Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy past 12 months? Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed of Vital Records, After this certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? page ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other; Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA 1 ✓ Yes 2 No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural subject accidentally asphyxiated neral Director: Pending 1 Yes 2 X No Fd 5/26/10 Fd 10:30 am 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4630~Egypt~Rd . Cambridge, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined Funeral (Specify) house Homicide 29a. Certifier completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 27, 2010 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month P Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 26 per phys. G904 6/4/10 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 5/25/2010 Mary Brown Mallon 5:25 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4303 Conowingo Road Harford Darlington Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M XCX Yrs. 6/26/1937 Director 218-36-2809 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location s 23a or 28a-f show ust be notified at 1 □ Yes 2√□ No Director MD Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 3500 Scarboro Road Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
snt: If item 27 is marked other than "natural", or items 23. 21154 USA 1. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Public Utility 12 Dispatcher Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be P Edward Brown Georgeanna Carr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr Robert Wilmoth/Cousin 3500 Scarboro Road, Street, MD 21154 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/29/2010 Emory Cemetery Street, MD 21. Signature of Furieral Service L 22. Name and Address of Facility Harkins F.H.Inc. Delta, PA 17314 Joliuso Approximate Interval Between Onset and Death 23a. Part1. Enter the diseat, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician atherosclerotic cardiovascular disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner huper tension if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of): Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed hyper Cholestero lemina
Due to (or as a consequence of): the burial-tran P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. Completed by type ener's 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hypothypoidism autopsy performed? Yes 2⊠No 2 🗀 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Living Medical Certification: To funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division 1 Natural 5 ☐ Pending investigation fter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mariner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

DHMH 17 Rev 1/2001

Dr

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Ste

nance

phanie

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

-inder

32. Registrar's Signature

29c. License number 0 00 43 9 0 9

902 AverillRd Joppa, mo 21085

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25 Day Physician/ Dorothy Geneva Merkel 4:59 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c, County of Death Prince George's Doctors Community Hospital Lanham 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 1 □ M 2 🖫 F March 23, 1938 220-34-3033 72 Marvland Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Bowie 1 Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 9411 Old Laurel Bowie Road 20720 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 Nidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name *(First, Middle, Last)* Charles T. Woods 18. Mother's Name (First, Middle, Maiden Surname) Margaret Houston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9505 Old Laurel Bowie Road Bowie, Maryland 20720 Donna K. Kreitzer -daughter 20a. Method of Disposition
1 N Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State First Till Ferally Childhoof 5/28/2010 4 ☐ Donation 5 ☐ Other (Specify) Bowie, Maryland Bowie Cemetery 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Darelel VB 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death)) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown 4 Pregnant 9 Unknown Pregnant at time of death Other (specify) after death.

Director: After this certificate has been signed by the a in by the funeral director, page 2 should be detached it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? _1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1. Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) MDD60545 05/26/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alfie Mingo 8118 Good hackld, Lanham, MD. 20706 State Registrar

DHMH 17 Rev 7/2009

DOLOTHY

				e Type or Pri								and the second s
			1 - For Amend Item State Registrar	25 per me	agylo2	d .66/6 9 Cer	7 2010allb tificate of L	Health and N Death	Mental Hy	giene /_ Reg. No.	UIU	646/1
	Physicia Medic		1. Decedent's Name (First, Middle, L Kenneth S.	ast) Manning	Jr				2. Date of De Month	Day	Year 2010	3. Time of Death
andy	Examin		4a. Facility Name (if not institution, gi	ve street and number)		-	4b. City, Town, or Location of Death 4c. County					h
	Farmeral		Seasons Hospi 5. Social Security Number 6.		In vre la	st birthday)	Randa If Under 1 Year	Llstown I If Under 24 Hrs.	8. Date of Bir		1timo	re thplace (State or Foreign
	Funeral Director		154-20-6711	1 x M 2 □ F	80	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 1929	Cor	untry) Jersey
	t ow	L	Usual Residence of Decedent 10a, State 10b, County			, Town or Lo	oction					
	arylan a-f sh fied a	Director	DE Susse		,	lmar	Jation					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	or 28	١	10e. Street and Number	A	De	IlliaI_	10f. Zip Code			10g. Citizen	of What Co	untry?
	n with	Funeral	6516 Delmar Roa	ıd			19940			U.S.A	.S.A.	
	r item		11. Marital Status 1 ☐ Never Married 2 ☒ Married	12. Was Decedent E Armed Forces? 1 X Yes 2		14	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp ın, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Ame Black, White	rican Indian, e, etc.
980	s after ral", o Exam	ed by	3 Widowed 4 Divorced	1 LAYYes 2 □ If Yes, Give Year or Dates.	No 194 195	1	☐ Yes 2 🔀 No	Specify:		Spec	oify: wh	nite
2-0	"natu "natu dical	plete	15. Decedent's (Specify only highest			16a. Deced	lent's Usual Occup	ation during most of work	ina	16b. Kind o	f Business	Industry
121	the lived within /2 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	+)	life. Do	O NOT use retired) ervisor	g		to10	a ommii	nications
1d 2	other other	Be	17. Father's Name (First, Middle, Last	t)		Supe	1 1 1 5 0 1	18. Mother's Nam	e (First, Middle,			liteations
ylar	id be t Menta arked atic ev	욘	Kenneth S. Mann	ing, Sr.				Ethel A	Austin			
Baltimore, Maryland 21215-0036	3.2 should be file alth and Mental H 27 is marked o 127 is marked o 127 is marked o		19a. Informant's Name/Relationship		,	100		and Number or Run				Code)
<u>စ်</u>	Healt Healt tem 2		Margaret L. Mar 20a. Method of Disposition	ming (Wife	-i		Delmar R	-	nar, DE	19940 20c. Locatio		Town, State
om.	Раge 1 ment of I ant; If it ury or o		1 🔀 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spe		Ce	emetery, cren	natory or other place Mem. Parl	e)			,	Maryland
alti	permit. Fage I and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If fire ZI is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lice		WILC		. Name and Addres		Short Fu			naryrana
<u> </u>	8 A E 8 5		- Junel	100				ove Stree			DE 19	- 1
×			23a. Part 1. Enter the disease, or co shock, or he at foliure. List only Immediate Cause (Final	one cause on each line		1 1			or respiratory an	rest,		Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Spinh Due to (or as a			hemorrhag	2			-	(0)
	Physician/ Medical Examiner	er	Sequentially list conditions,									
7	d insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a	Due to (or as a consequence of):							
	ian and	al Ex	cause. Enter Underlying Cause (Disease or itinjury that initiated events resulting in death) Last CERTIFICATION APPROVED BY MEDICAL EXAMINER CERTIFICATION APPROVED BY MEDICAL EXAMINER CERTIFICATION APPROVED BY MEDICAL EXAMINER CERTIFICATION APPROVED BY MEDICAL EXAMINER									
68760	physicist the bu	edica		d							-	
89	nding use as	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			1-, .			23d.	Date of del	ivery
P.O. Box 68760	been signed by the attending I should be detached for use as	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnanc Other (specify)	;y			Month	Day Year
P.O.	ed by 1 detach		Part II. Other significant conditions	contributing to death be	ut not resu	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use co	ontribute to	the cause of death?
	, 50 %	ed by							1 🗆	Yes 2 □ N	o 3 □ Pı	robably 4 🗹 Unknown
cords,	as bee	Completed							24a. Was			topsy findings available completion of cause of
Re	certificate has k	Con							perfo	ormed?	death?	2 🗆 No
ital E	certifi	Be c	25. Was case referred to fedical examiner? 1 X Yes 2 1 No	Hospital:			Othe	ace of Death (Chec		-1	in pat	ient hospice
	er this reral di	te: To	27. Manner of Death	1 ☐ Inpatie 28a. Date of injur (Month, Day	y	ER/Outpatien 28b. Time of	28c. Injury	/ at	ome 5 L Residence 28d. Describe h			ify)
lon	eath. or: Aft the fur	ifical	1 Natural 5 Pending 2 Accident Investigati 3 Suicide 6 Could not	on	rear)	injury	M 1 🗆	? Yes 2 □ No				
Division of Vital Records,	after d Direct d in by	Certificate:	4 Homicide determine		ry - At hor . <i>(Specify)</i>	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow		nber or Rur	al Route Number,
I Hoenit	within 24 hours after death. To the Funeral Director, After this certificate h completed filled in by the funeral director, page	Medical	(Check 2 ∟ Medical Exa	nysician: To the best of miner: On the basis of ex	amination	and/or invest	igation, in my opinic	n, death occurred a	t the time, date a	and place, and	due to the o	cause(s) and manner stated.
P ch	within	_	29b. Signature and title of certifief			*	29c. License			29d. Date sig	ned (Month	
	IMP		30. Name and address of person who NSNUMENE · R 31. Date filed (Month, Day, Year) NAY 21 2	completed cause of de	eath (Item	23a) (Type, P 8355m	rint). 114 Avenu	10,5-23	5 , Ba	Itimor	eIA	1D. 21209
	Stat Registra	e ir	31. Date filed (Month, Day, Year) NAY 2 1 2	010 32 egistra	r's Signatu	1. pa	we					

10-03909 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Almonda McCarthy 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day May 22, 2010 0405 hrs Medical Examiner Lec 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hagerstown Washington 18601 Roxbury Road 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex If Under 24Hrs. **Funeral** Foreign Country) Min Months Days Hours Director 1 X M 2 F MD 219-62-8002 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location iny 10b. County 1 Yes 2 No or 28a-f show Eden MD Wicomico Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.

ont: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10g. Citizen of What Country 10f. Zip Code 10e Street and Number 듑 28164 Stanford Koad 21893 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes 1 Yes 2 No specify: Specify: Black 4 Divorced If Yes, Give Year Š 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 None Disabled 18.Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) or other traumatic Stanford Road 21872 Sister Eden 28164 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: 22 Name and Address of Facility 917. W Isabella st tuniral MO DISO Approximate Interval Between Onset and se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** /Medica Hypertensive cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by the attending physician and ached for use as the burial - transit The law requires that the death certificate be executed Physician/Medica X UNPENDED AMENDED 23a, 27, per ME G904 6/18/10 TT Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> 1 Yes 2 V No 3 Probably 4 Unknown Completed After this certificate has been 24o. Were autopsy findings available 24a. Was an prior to completion of cause of performed? death? ✓ Yes 2 No 2 No 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cerrifi. 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other4 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 2 ER/Outpatient 3 1 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d, Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending Director: d in by the f Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the company of the date and place, and due to the company of the date and place. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

and manner stated.

Assistant Medical Examiner

29b. Signature and title of certifier

Margarita Korell MD.

31. Date filed (Mo.

Ince

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

May 22, 2010

State Registra

egistrar's Signatu

		-	For State Registrar		State of M	arylanc		artment of F tificate of L	tealth and I De <i>ath</i>	Mental Hy	giene Reg. N		
	Physicia Medic		1. Decedent's Name (First, M	liddle, Last)	DONALD		MILL			2. Date of De Month	ath	ay _ Year	3. Time of Death 3
4	Examin	er	4a. Facility Name (if not insti		Medienc	CH	star		Location of Death	,	4	c. County of Death	40
	Funeral Director		5. Social Security Number 216–28–7877 Usual Residence of Decede		M 2 □ F 7. Ag	je (In yrs. las 78	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H/s. Hours Min.	8. Date of Bir (Month, Da JAN . 29	th ly, Year)	932 9. Birthp Count MAR	place (State or Foreign try) XYLAND
	e filed within 72 hours after death with the Maryland tabl hygiene. So other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	irector		JSSEX		10c. City,	Town or Loc	VILLE					0d. Inside City Limits 1 ☐ Yes 2 🕅 No
	th with the ms 23a or must be n	Funeral Director	10e. Street and Number 38751 EAST			From in 11.0	lan s	10f. Zip Code 1997.		anifu Van au Na		USA	
920	s after dea ral", or itel Examiner	by	11. Marital Status 1 ☐ Never Married 2 ② 3 ☐ Widowed 4 ☐ Div	Married	12. Was Decedent Armed Forces? 1 A Yes 2 If Yes, Give Year or Dates.	No	1	Vas Decedent of Hi Yes, specify Cuba	n, Mexican, Puerto	ecity fes or No- Rican, etc.)		14. Race - Americ Black, White, e Specify: WHI	etc.
21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at	Completed	15. De (Specify only Elementary/Seconday (0		cation		16a. Deced (Give I life. De	lent's Usual Occup kind of work done o O NOT use retired) CLERK	ation during most of wor	king		Kind of Business Ind	dustry
land 2	e 1 and 2 should be filed within 72 of Health and Mental Hyglene. If item 27 is marked other than "I nother traumatic event, the Med	To Be C	17. Father's Name (First, Mic ALBERT		RLES	MILI		CLERK	18. Mother's Nar			Surname)	INGTON
Maryland	d 2 should alth and M 127 is ma er traumat		19a. Informant's Name/Rela									or Town, State, Zip C	
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crem 4 ☐ Dopatron 5 ☐ Of	ner (Specify)	1	cer	metery, cren	sition (Name of natory or other plac OF DELM		Date 3/10		Location - City or To	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Ser	vice/License	ant	>		. Name and Addres	,	HOME, SE	LBY	VILLE, DE	. 19975
	Physician/		23a. Part 1. Enter the disea shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)				Do not ente		g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical Examiner	er	Sequentially list conditions, if any, leading to immediate		Due to (or as		(40.00					
	ate be executed physician and the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	1	Due to (or as		·						
8760	ifficate be on physicial as the bur		IF FEMALE:	L	1								
. Box 68	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and ited filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnan in the past 12 months? 1 Yes 2 No 9 Unknown	20	3c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	sy		:	23d. Date of delive Month	ery Day Year
ds, P.O.	requires that the des been signed by the s should be detached to	by	Part II. Other significant co	nditions con	tributing to death t	out not resul	ting in the u	nderlying cause giv	ven in Part I.			use contribute to th	ne cause of death?
Division of Vital Records,	The law requi	Completed		* '						24a. Was auto 1 Yes		prior to cor death?	osy findings available mpletio <i>n</i> of cause of 2 No
f Vital	Physician: The this certificate al director, pag	To Be	25. Was case referred to me examiner? 1 Yes No 27. Manner of Death	_				t 3 DOA Othe	4 L Nursing H	ome 5 Resi		6 ☐ Other (Specify))
sion o	al or Attending I s after death. I Director: After d in by the funer	Certificate:	Natural 5 F 2 Accident Ir 3 Suicide 6 0	ending vestigation ould not be	28a. Date of inju (Month, Da	y, Year)	28b. Time of injury	28c. Injury work M 1 □	y at ?? Yes 2 □ No	28d. Describe h		nd Number or Rural	Route Number
Divi	spital or A hours after neral Dire		29a. Certifier Cert	etermined fying Physic	building, et	c. (Specify) my knowled	dge, death o	occured at the time	, date and place, a	City or Tov	vn, State	e) and manner as state	d.
	To the Hospital or a within 24 hours after To the Funeral Direction completed filled in b	Medical	(Check 2 L Med	cal Examine fying Nurse	er: On the basis of e	examination a	and/or invest	igation, in my opinio leath occurred at the 29c. License	on, death occurred a e time, date and pla e number	at the time, date a	and place e cause 29d. D	e, and due to the cau (s) and manner as sta ate signed (Month, L	use(s) and manner stated. ated.
	7 mg		30. Name and address of pe	rson who con	mpleted cause of o	leath (Item 2	23a) (Type, F	rint) D 63		4		118/10.	
	Star		יאכטדיי	19 20	32 Registr	ar's Signatu	5140P	E Dt.,	SAUSS	UKJ, M	U _l .	402	
	Registra	e II			/		-						

State Registrar

30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

and manner stated

29d. Date signed (Month, Day, Year)

May 25, 2010

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 2010 Albert Neyers AM 212 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** 4b. City, Town, or Location of Death niversity of Manyland Medical Center Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Birthplace (State or Foreign
Country)

Dannville, PA 5. Social Security Numb 198–30–4651 7. Age (In yrs. last birthday) **Funeral** Months 1 JM 2 DF Director 1940 69 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 □ No Montgomery MD Germantown 10e. Street and Number 10f. Zin Code 10g, Citizen of What Country? Funeral 13548 Jamieson Place 20874 items death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after di Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i 1 Never Married 2 Married 1 Yes 2 1963 If Yes, Give 1968 Year or Dates 1968 Completed by Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Control Exterminator 12 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Blanche Cohen Dr. Harry Joseph Meyers other traumatic 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13548 Jamieson Place, Germantown, MD 20874 Sharon S.Meyers/Wife Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) any injury or 5/24/2010 24/2010 Farrisburg, PA J.J. Hartenstein Mortuary, Inc Kesher Israel Cemetery 22, Name and Address of Facility Signature of Funeral Septice Licensee PA 17349 24 N. Second St., New Freedom, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ intracranial hemorrhage / stroke disease or condition resulting in death) werk Medical Due to (or as a consequence of): Examiner 10 days carotid artery dissections Seque Itally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) 3. veeks A aortic dissections tupe sician and burial-trans that initiated events Due to or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [출 fibrilation Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed certificate 1 Yes 2 No Hospital or Attending Physician; **Division of Vital** 25. Was case referred to medical funeral director, æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No npatient 2 ER/Outpatient 3 DOA ျှ 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After is completed filled in by the funeral 1. Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical

15+1 State

Registrar

Suzanne 31. Date filed (Month, Day, Year) JUN 0 4 2010

29a. Certifier

only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SUZANNE SIE FENT 2Z S. Green Greene Registrar's Signat

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

659530533

Raltimore.

29d. Date signed (Month, Day, Year)

21201

5/22/10

NO

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 10:05 PM James Robert Nelson. Sr May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner St. Mary's Nursing Center Mary's Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of Dira. (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Hours Min Country)
Maryland Months Director 80Yrs 215-30-0228 Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. Stor is marked other than "natural", or items 23a or 28a-f show there traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland St. Mary's Charlotte Hall 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be i Funeral 30350 Pine Street 20622 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mills Ne1son Emma Tennison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Helen Nelson / Wife 30350 Pine Street, Charlotte Hall, MD 20622 item 27 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20b Place of Disposition (Name of 20c. Location - City or Town, State . Page 1 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) May 26, 2010 4 Donation 5 Other (Specify) Charles Memorial Gardens Leonardtown, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease On disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Yes 2 🗆 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 No Yes Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yeş 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 29d. Date signed (Month, Day, Year) M.D.

State Registrar gistrar's Signature

26840 Point Lookout Road, Leonardtown, MD 20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

Rakhi Krishnan,

MAY 25

31. Date filed (Month, Day, Year,

D60888

05

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Dawn Elizabeth Norman Μ May 18, 2010 4:40 A 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 9010 Flintwood Court Fort Washington Prince George's Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Feb 2, 1939 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 579 74 4482 Months Days Hours Min. 1 □ M 2 🗓 F England 71 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ∐Yes 2 XXio Maryland | Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9010 Flintwood Court 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ⊟Yes 2 V If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 **XX**No 1 ☐ Yes 2√√No Specify. Specify: White 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter Norman Ivy Byett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kymara James (Daughter) 9010 Flintwood Court, Fort Washington, MD 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 22, 2010 Clinton, MD Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria MO1140 Ferry Road, Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence uctive pulmonory disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent premant in the past 12 months? 1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🔽 1 ☐ Yes 2 ☐ No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

permit. Pages 1 and 2 Department of Health Important: If item 27 any injury or other tr once.

Physician

/Medical

10a, State

Director

Funeral

<u>6</u>

Completed

Be

ဥ

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show Jry or other traumatic event, the Medical Eventime I hast by notified at

Baltimore, Maryland 21215-0036

than "natural", or items 23a or 28a-f sho he Micdical Exandratin ust be notified at

Physician/Medical 2 Completed Be

4 Homicide

(Check only one)

29a. Certifier

and burial-trar physician the attending pl ed by the detached t signed by the director, Certification: To

Physician: The law requires that the death certificate be executed cate has been signated bage 2 should b certificate this filled in by the funeral ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t After t completely within 2

Division of Vital Records, P.O. Box 68760,

State Registrar

Medical

25. Was case referred to medical examiner? Other: 4 Nursing Home 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No

5 ☐ Pending investigation 6 Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

Surratts Rd. #201A Clinton

who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 10 n r

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Geneva Oney Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland 5. Social Security Number 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 6. Sex **Funeral** Months Days Hours Min. Country) 1 M 2 X F 80 218-28-1430 Director 01/31/1930 Virginia Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🔀 No Bedford Bedford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 205 White Oak Lane 15522 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify. 3 Divorced 4 Divorced Completed White Year or Dates 16a, Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with th and Mental Hygien ?**7 is marked other th** Press Operator Packaging Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jonah Joseph Richmond Rhoda Mae Bennett traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lawrence E. Oney / Husband 205 White Oak Lane, Bedford, PA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Memorial Park 05/15/2010 Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, of Funeral Service 404 Decatur Street, Cumberland, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death ned by the a detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 E 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director. After this completed filled in by the funeral i 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide 1 🗌 Yes 2 \square No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the f

State Registrar

3

MRX

29b. Signature and title of certifi

31. Date filed (Month, Day,

1221-E National Highway, LaVale, MD

21502

varra.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shiv C. Khanna, M.D.,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Beatrice Phillips /Medical May 10, 2010 04:10 PM 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frostburg Village Nursing Care Center Frostburg Allegany 5. Social Security Number **Funeral** If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 2 X F Min. Hours Director 215-16-4417 87 March 13, 1923 Maryland Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or Items 23a or 28a-f show 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Maryland Allegany Frostburg 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 100 Honeysuckle Lane 10g. Citizen of What Country? 21532-Apt. 318 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 ☐ Divorced White traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housekeeping U.S. government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John E. Merbaugh Catherine Mansfield 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Penny Ryan daughter 14102 Upper Georges Creek Frostburg Maryland 21532-20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Hill Cemetery May 13, 2010 Lonaconing Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility lieb.la Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CONGESTIVE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CORDNAR Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE 23b. Was decedent pregnant in the past 12 months? yes, outcome of pregnancy
Live birth 2 Fetal death 23d. Date of delivery ঠ 3 Ectopic pregnancy 4 Pregnant at time of death Month Day as been signed by the 2 should be detached ☐Yes 2 No 5 Other (specify) 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 □No 2 □No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 □ Yes within 24 hours after death To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Oidhu

31. Date filed (Month, Day, MAY 12

1) 2690

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month PM 2145 **Physician** May 2010 4a. Facility Name (If not institution, give street and number) inder Leroy /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner Cambridge

If Under 1 Year | If Under 24 Hrs. |
Months | Days | Hours | Min. | Dorchester Dorchester General Hospital Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 220-28-4975 Usual Residence of Decedent Marylano Director 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ir than "naturel", or Items 23a or 28a-f shov If a Medical Examinar must be notified at 1 Yes 2 No Director Vienna Jorchester 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4896 50 186 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No. 95 4 11. Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates: 1956 Black Maryland 21215-0036 1 Yes 2 No Specify: Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Supervisor Manufactur
18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Jackson Lenora Thomas nder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

m State

Date

20d. Location - City or Town, State permit. Pages 1 and 2:
Department of Health at Important: if item 27 is eny injury or other tratonce. 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 27/10 Veterans Cemetery HUYLOCK, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address Facility
HENRY FUNEYO 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. HENRY Cambridge, MD. 21613 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) My ocardial Infarction 4/ hour Physician PROBable acute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine nding physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 5 Other (specify) signed by the all d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 Probably 4 Unknown 5/0 DERMORE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an due do autonomic DYPOTENS:an autopsy performed? Yes 2 2 No Dys Function 1 Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient Medical Certification: To 3□ DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural
2 Accident Injury 5 Pending 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours af To the Funeral D 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Baltimore,

o

of Vital

State Registrar

Ereacrita

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) teachers Affains Dutpatient Clerce

0005866

830 ChESaperte DRIVE

5/20/10

S1 4 M

2. Registrar's Signature

1. SANOS-1ECSER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 20/0 Physician/ Rannells Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland WMHS-RMC 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 🖳 M 2 🗆 F Months Days Hours May 25 80 Director 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 2 should be filed within 72 hours after death with the Maryland that and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at Director Cumberland MD Allegany 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 10810 Rannells Road 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates WW II white Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Potomac Valley TV vice president Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) မ Anita R. (Moler) Rannells J. Holland Rannells 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O.Box 630 Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. daughte Patricia Bennett 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State 5/15/2010 Cresaptown MD 4 ☐ Donation, 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ crite disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dabetic Sequentially list conditions, Examiner rany, reading to in reduce cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performed' 1 🗌 Yes 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Z No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D21244 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nds BROADWAY Year) 31. Date filed (Month, Day, Registrar

			Pleas	se Type or Print in B				-		ible.	17557
<u> </u>			For State Registrar	State of Maryland	-	tificate of L			Reg. No.	! U	17337
	Physicia Medic		1. Decedent's Name <i>(First, Middl</i> e, Clarence	Last) William		Riley	7	2. Date of Dear	th Day	Year	3. Time of Death 0020 M
	Examir	er	4a. Facility Name (if not institution, Western MD Regi	^{give} street and number) onal Medical Cen	ter		r Location of Death perland		4c. County	of Death Alleg	gany
	Funeral Director		232-62-6372	5. Sex 7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 08/24/1	Year)	Counti	lace (State or Foreign iry) Virginia
	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County MD A1	legany 10c. City,	Town or Loc	cation Cumberlan	d			10	0d. Inside City Limits 1 🏋 Yes 2 □ No
	with the M 23a or 28 ist be noti	eral Dir	10e. Street and Number	ic Street, Apt 5	01	10f. Zip Code	21502		10g. Citizen of V	What Count	try?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
21215-0036	/ithin 72 hour iene. r than "natu the Medical	Complete	15. Decedent (Specify only highes Elementary/Seconday (0-12)	's Education t grade completed) College (1-4 or 5+)	(Give I	lent's Usual Occup kind of work done of NOT use retired) Owner	during most of work	ing	16b. Kind of Bu		lustry
Maryland 2	d be filed v Aental Hyg irked othe	To Be	17. Father's Name (First, Middle, La Walter		Riley		18. Mother's Nam Leafy	e (First, Middle, N		e) pats	
	d 2 should raith and N n 27 is m é er trauma		19a. Informant's Name/Relationshi Judy Furstenbe	rg / step-daught	19b. Majlir er 42	g Address <i>(Street a</i> 21 Grand	and Number or Run Avenue,	al Route Number, Cumberla	City or Town, S .nd,MD	tate, <i>Zip</i> Co 2150	ode))2
Baltimore,	Page 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1 🏹 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp	Removal from State Cel	^{metery, cren} tlawn	sition (Name of natory or other place Mem • Gar	eden s 05/	Date 14/2010	20c. Location - LaVal	Le, MI	D
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Li	adams	4 (04 Decati	ır Street	, Cumber	land, M		Home, P.A. 1502
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or described in the shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that caused the death. ly one cause on each line. a. Due to (or as a conseque	Righ		g, such as cardiac o	br respiratory arre	Cent		Approximate Interval Between Onset and Death
	uted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	b. Due to (or as a conseque	scle	vasis	<u> </u>			Ť	years
09	ate be executed hysician and the burial-transit	ja	resulting in death) Last	Due to (or as a conseque	nce of):	ellit	u,				years
, Box 68760	he death certificate by y the attending physic iched for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live Birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3	Ectopic pregnand Other (specify)	ey		1	te of deliver	Pry Day Year
cords, P.O.	Hospital or Attending Physician: The law requires that the death certificate be executed 42 hours abter death. Luneral Director, After this certificate has been signed by the attending physician and tenderal Director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, page 2 should be detached for use as the burial-transitied in by the funeral director, based on the funeral director and the funeral director	Completed by P	Part II. Other significant condition	s contributing to death but not resul	ting in the u	nderlying cause giv	ven in Part I.	1 🗆 Yo	es 2 No	Were autoportion to com	e cause of death? Tably 4 Unknown Day findings available inpletion of cause of
Division of Vital Records,	Physician: The law this certificate has braid director, page 2 s	Be	25. Was case referred to medical examiner? 1 Yes 2	Hospital:		Oth	ace of Death (Checker:	k only one)	2 No 1	death?	
on of V	nding Physath. r: After this e funeral di	icate: To	27 Manner of Death Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	R/Outpatien 8b. Time of injury	28c. Injury work	4 □ Nursing Ho y at	ome 5 Reside 28d. Describe ho			
Division	To the Hospital or Attending Is within 24 hours after death. To the Funeral Director: After completed filled in by the funer	al Certificate:	3 Suicide 6 Could not 4 Homicide determin		e, farm, stre	et, factory, office		28f. Location (St. City or Town		er or Rural F	Route Number,
	To the Hospi within 24 hou To the Funer completed fil	Medical	(Check 2 Medical Ex	Physician: To the best of my knowled aminer: On the basis of examination a lurse Practioner: To the best of my knowledge.	and/or invest	igation, in my opinio leath occurred at th	on, death occurred a e time, date and plac	t the time, date an e, and due to the	d place, and due cause(s) and ma	e to the caus anner as star	se(s) and manner stated ated.
	₽ ₹ ₽ 8 ∴		29b. Signature and title of certifier	Callen	_	29c. License	-4411	2	9d. Date signed 5 - //	-16) rear)
	nes		/ /	no completed cause of death (Item 2 Llkins, M.D., 60			enue, Cum	berland,	MD 21	1502	
	Stat Registra		31. Date filed (Month, Day Year)	32. Registrar's Signatur	e Ked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2010 Frank Eugene Stanek May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney Montgomery Social Security Number 6. Sex 1 🖾 M 2 🗆 F 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours July 8, 1935 Rhode Island Director 042-28-5720 74 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2921 N. Leisure World Blvd, #225 20906 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Owner (unk) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unk) (unk) ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Stanek/son 3410 Forest Wood Drive Brookeville, Maryland 20833 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Woodbine, Maryland 4 Donation 5 Other (Specify) Final Journey Crematory 5/20/2010 Sign for re of Funeral Service Licensee Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD Thomas M00957 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hortic Physician, disease or condition resulting in death) minutes Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying (or as a consequence of signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy page 2 perform 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 □ No Be completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred 1 Natural injury 5 Pending 2 🗌 No hours after death uneral Director: / Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

within 2 To the F

State Registrar only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Montgomery

3 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0028429

General Hospital 18101 Prince Phillip Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 17559

State of Maryland / Department of Health and Mental Hygiene

1	Stat	e	Robert Jayes, M. 31. Date filed (Month, Payyear) 0	D. 2150 P	ennsylva ar's Signature	nia A	renue,	NW W	lashir	igton,	DC	20081		
, 2	41		30. Name and address of person who							L.		2		
Islot 2							MD17					ay 20,		ui/
	the Hithin 24 orthe Formplett			urse Practioner: To the		edge, death or		e time, date		and due to the	e cause(s		s stated.	
	Hospita 4 hours Funeral ed filler	Medical		nysician: To the best of miner: On the basis of e										nd manner stated.
)ivis	al or At:		4 Homicide determine		ury - At home, far c. (Specify)	m, street, fac	tory, office		28	3f. Location (S City or Tow		d Number or R	ural Route	Number,
on	I or Attending Prhysician: The law requires that the death certificate be examined to the death. Director: After this certificate has been signed by the attending physician d in by the funeral director, page 2 should be detached for use as the burity of the funeral director.	ifical	1 Natural 5 ☐ Pending 2 ☐ Accident Investigati 3 ☐ Suicide 6 ☐ Could not	on		jury M		? Yes 2 🗆	-					
of V	g Physer this reral direction	te: To	27. Manner of Death	1 ☐ Inpati 28a. Date of inju (Month, Date		me of	28c. Injury	4 LJNu ∕at		e 5 Resid d. Describe h		XOther (Spe occurred		Living
ta	sician: certific rector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Othe		th (Check o	-3		/Tibe	Ass	sisted
Rec	The lavate has	Comp								autop perfo 1 ☐ Yes	rmed?	death?		on of cause of
ords	v requir s been s should	Jetec		Cararovas	Curur D	Locase				24a. Was i	an	24b. Were a	utopsy fina	dings available
), P.(es that signed be det	l by F	Part II. Other significant conditions Atherosclerotic			-	ng cause giv	en in Part	1.			se contribute t		se of death?
Division of Vital Records, P.O. Box	the dea by the stached t	hysic	1 Yes 2 No 9 Unknown	9 🗆 Unknown										_
39 XC	ath certi		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal death	3 ☐ Ectop		;y				23d. Date of d Month	elivery Day	Year
8760	ificate ig phys as the	Medic	IE FEMALE:	■ d			-							
0	be exe. sician a burial-1		resulting in death) Last	Due to (or as	a consequence o	т):								
	cuted ind transit	Examiner	cause. Enter Underlying Cause (Disease or imjury that initiated events	0.0000	f):									
		iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence o	f):								
	Medical Examiner		resulting in death)		a consequence o		.						, y	مس
	Pnysician		shock or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line						,			Interv Onse	ral Between t and Death
Ω	20 E 20 20	()	23a. Part I. Enter the disease, or co	mplications that caused	M00957	Bever	rly L.	Hecl	krotte	e, P.A	. Cl	arksvī]		4 MD 21029 eximate
altin	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Spe 21. Sign ture of Funeral Service Light		Final (odbine, P.O. Bo		
altimore,	- 5 = 5		20a. Method of Disposition 1 Burial 2 Cremation 3			y, crematory o	or other plac		Da			ocation - City o		
	and 2 shou Health and tem 27 is m		Roberta B. Schne		34	01 38t	h Stre				Was	hingtor	n, DC	
Maryland	should be n and Menti 7 is marked raumatic e	욘	Alfred K. S	chneidman (Type, Print)	10h	Mailing Add	ess (Street		rah eror Bural B	Duski		Town, State, 2	Zip Codel	
nd 2	filed w tal Hygi ed other event, t	Be	17. Father's Name (First, Middle, Last	t)			ULT	18. Mothe		First, Middle,	Maiden			
21215-0036	vithin 7; iene. r than the Me		Elementary/Seconday (0-12)	College (1-4 or 5		ife. DO NOT oreign	una ratiradi	ice I	-	' I	Fed	eral Go	overn	ment
5-00	2 hours "natura dical E	Completed	15. Decedent's (Specify only highest		16a.	Decedent's L (Give kind of	Isual Occup	ation durina mosi	t of working	, 1	16b. K	ind of Busines		
36	all", or i	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 ☐			s 2 XNo			oan, etc.)		Black, Wh Specify:	ite, etc. Whit	e
	leath w items 2 er mus	Funeral	3401 38th Stre	et, NW A 12. Was Decedent I Armed Forces?	Apt 506 Ever in U.S.	13. Was De		016 ispanic Orig	gin? (Speci	fy Yes or No-		United 14. Race - Am	erican Ind	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at		10e. Street and Number	o		10f.	Zip Code	21.6				izen of What C		
	Maryla 28a-f s otified	Director	DC		Wa	shingt	on						1	Yes 2 □ No
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10d. Ins	side City Limits
	Funeral Director		5. Social Security Number 6. 186–18–9884	Sex 1 X M 2 □ F	e (In yrs. last birth 87	Yrs. Mont		Hours	Min.	8. Date of Birt (Month, Da June 2	Year)	922 Pe	ountry)	State or Foreign lvania
~ <			Rebecca House	Cov. 17 Am	a // la land b inth	efoul If I Ir	Potor	nac I if Under	24 Ure	0 D-t(Di-		Montgo		State on Foreign
	Medic Examin		Harold Fre 4a. Facility Name (if not institution, gi		neidman	4b. C	ity, Town, or	r Location o	of Death	May	18, 4c.	2010 County of De		1:25 P ^M
	Physicia	n/	1. Decedent's Name (First, Middle, L	,						2. Date of Dea	Da	y Year		ime of Death
		•	State Registrar			Certific	ate of L	Death			Reg. No			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland, Bepartment of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 18^{Day} Month May Physician/ 2010 p^{M} 11:50 Sheila Zorb Sartwell Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Morningside House of Ellicott City Ellicott City Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 1 □ M 2 💁 Days Hours Min. 07/24/1931 MD Director 547-40-0044 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State Director MD Howard Ellicott City 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 4723 Bates Drive 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify. Specify: 3 XWidowed 4 ☐ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Bookkeeper Auto Body Repair Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Thomas Tonkins Mary Todd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health a item 27 i Charles Zorb - son 4723 Bates Drive Ellicott City, MD 21043 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven 05/24/2010 Silver Spring, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. M01411 21. Signature of Funeral Service Licensee fault & Old Columbia Pike Ellicott City, MD 21043 4112 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) Month Day by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page performed 2 🗌 No After this certificate 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 No 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work 5 Pending To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 2010 30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kalhmore Maylard 2/12 King neck Road 12 15acle Sahanalin 201-109 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Cewel! Year telen 12 P M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 217-32-2645 **Director** 77 01/20/1933 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No Maryland St. Mary's Inigoes 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 48565 Beachville Road Funeral 20684 United States Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🏋 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify þ 3 Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည David L. Somerville Mary Fenwick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Calvert L. Sewell/Husband P.O. Box 136, St. Inigoes, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Number 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Peter Claver Cem 05/27/2010 St. Inigoes, Maryland 21. Singling of uneral service Licensee

22. Name and Address of Facility

22. Name and Address of Facility

23. Brinsfield Funeral Homeral Ho 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death)) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Pregnant at time of death Day 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: $_{4} \square$ Nursing Home 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of Injury 5 Residence 6 Other (Specify) 27. Manner of Death 1 A Natural 2 Accident 28b. Time of Injury at Work? Certification: 28d. Describe how injury occurred After 5 Pending investigation Injury death. 1 TYes 2 □ No Director: A 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. onel 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

6 RMB

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) 32. Re MAY 2 6 2010

vankata

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Narla

32. Registrar's Signature

M.D

M.D

B. parks

RES-000

22,2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Elizabeth 9:24PM Senior 2010 100 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Medical La Plata Civista harles If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) | Min. | May 9,1938 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2√ F 578-50-3984 72 Washington DC Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ratural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and proce. 1 ☐ Yes 2 No Director MD Charles La Plata 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6345 Hidden Valley Drive 20646 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Ye ar or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married SCHIOC, $\sqrt{|OCC|^2}$ /¶. | Baltimore, Maryland 21215-0036 1 □Yes 2 ₩ No Specify: ₽ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Payroll Clerk Federal Govt. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Philip H. Rupprecht Bernice Hickman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shelly Senior /Daughter 6345 Hidden Valley Drive, La Plata, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Rest Cemetery 5/21/2010 La Plata, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AREHART-ECHOLS FUNERAL HOME, PA. Dave Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 0 1000 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Day Year 5 Other (specify) the detached 9 Unknown á signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Hospital or Attending Physician: The certificate 2 1No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending the Funeral Director; Af 1 □Yes 2 □No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b, Signature and title of certifier 29c. License number 2 29d. Date signed (Month, Day, Year)

State

MR-08691

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Denve S. garle

M.D.

MAY 20

32. Registrar's Signature

KAMAKSHI BAIG 31. Date filed (Month, Day, Year)

6620 CRAIN HWYSUITE 102, LAPLATA MD 20646

18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1)0056949

17563

			State Registrar		,	C	ertificate	of Dea	ath		Reg. N	lo.		
	Discontinuit	/	1. Decedent's Name (First, Middle,	Last)						2. Date of D	eath			ne of Death
	Physicia Medi		Alphonse Jacob							Month May	2	1, 201		00 P M
,, 44.5	Examir		4a. Facility Name (if not institution, g	ive street and number)			4b. City, To	own, or Loc	ation of Death			c. County of De		
	,	Ш	14195 Gremlin La					Hancock					gton	
ı	Funeral Director		5. Social Security Number 215-36-6117 Usual Residence of Decedent	. Sex 1 X M 2 □ F	je (In yrs. la	ast birthday 70 Yrs.	Montho		Jnder 24 Hrs. ours Min.	8. Date of Bi (Month, D 08/21/		9. B	ountry)	te or Foreign
	nd how at	=	10a. State 10b. County		10c. City	y, Town or I	Location				-		10d Insid	e City Limits
	aryla ia-f s ified	Director	MD Washir	oton		Hanc								Yes 2 X No
	or 28	늅	10e. Street and Number				10f. Zip 0	Code			100.0	Citizen of What C		100 2 45 110
	tth with t ms 23a must be	Funeral	14195 Gremlin I				217	50				USA		
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	Narital Status Never Married 2 Married 3 □ Widowed 4 □ Divorced	If Yes, Give		5.	If Yes, specify	y Cuban, M	exican, Puerto	ecify Yes or No Rican, etc.)		14. Race - Am Black, Wh Specify: 171	ite, etc.	,
Maryland 21215-0036	ours atura cal E	Completed	15. Decedent	Year or Dates.		160 Doo						L WI	nite	
712	72 h	臣	(Specify only highest	grade completed)	de completed) (Give k		e kind of work	lent's Usual Occupation kind of work done during most of working O NOT use retired)		ring	16b.	Kind of Busines	s Industry	
212	withir giene er the		Elementary/Seconday (0-12)	Callege (1-4 ar	o+)	l	rete Fi	•	r		Coi	nstructi	ion	
פַ	filed all Hyg	Be	17. Father's Name (First, Middle, Las	t)						ne (First, Middle				
/lai	d be Menta arked	욘	Jacob Edward Sh	pemaker				-	Goldie	Letiti	a We	eller		
an	shoul and I is ma							Street and N	lumber or Run	al Route Numb	er, City c	or Town, State, Z	ip Code)	-
≥.	ealth m 27		Rebecca J. Shoe	maker/Wife		141	95 Grem	nlin L	ane Ha	ncock,	MD 2	21750		
ore	of H		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	Domaval from State			position (Name ematory or other			Date	20c. l	_ocation - City o	r Town, State	,
Ĕ	Pagiment ment tant: jury o		4 Donation 5 Other (Spe	cify)			dge Cer		05/25	/2010	Han	cock, M	D	
Baltimore,	permit Depart Impor any in once.		21. Se nature of Funeral Service Lice	6	MOO 2		22. Name and		' 1			in Stre k,MD 21		68
			23a. Part 1. Enter the disease, or co	mplications that caused	the death							K,ID ZI	Approxi	
Ŧ	hysician/ Medical		shock, or heart failure List only Immediate Cause (Final disease or condition resulting in death)	0		Cyto	1 0	nco						Between nd Death
	Examiner			Due to (or as	a confequ	ence of):							· '	
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as:	a conseque	ence of):								
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or impury that initiated events											
	exect an an ial-tra	Ä	resulting in death) Last	C. Due to (or as	a conseque	ence of):								
Š	cate be executed physician and the burial-transit	lica		d										
09/8	certificate be executed nding physician and use as the burial-transi	Medical	IF FEMALE:											
Š R	death ne atte ed for	by Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🔲 Fetal	death 3	☐ Ectopic pre☐ Other (spec					23d. Date of de Month	Day	Year
л. О	that the	y P	Part II. Other significant conditions	contributing to death b	ut not resu	Ilting in the	underlying cau	use given in	Part I.	23e. Did t	obacco	use contribute to	the cause o	of death?
rds,	equires een sigr	eted b								1 🗷	Yes 2	□No 3□F	Probably 4	Unknown
Vital Records,	The law r ate has b page 2 sl	Completed								24a. Was autor perfo	osy ormed?	death?	itopsy finding completion o	gs available of cause of
<u>.</u>	sian: ertific ctor,		25. Was case referred to medical examiner?					26. Place of	Death (Check	_		01 1210	2 2 2 110	
>	hysic this o	은	1 ☐ Yes 2 🗷 No				ent 3 DOA	Other: 4 [Nursing Ho	me 5 Resid	dence (6 Other (Spec	cify)	_
ono :	ending Path.	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ AccidentInvestigati		y ; Year)	28b. Time o injury	of 28c.	. Injury at work? 1 Yes		28d. Describe h	ow inju	y occurred		
UIVISION OT	tal or Atto		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine			ne, farm, st	reet, factory, or	ffice		28f. Location (S City or Tow		d Number or Ru	ral Route Nu	mber,
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	Only one) 3 Certifying Nu	ysician: To the best of one of the basis of expression of the basis of expression of the basis o	amination	and/or inve	stigation, in my	opinion, dea	th occurred at	the time, date a	nd place	, and due to the	cause(s) and	
_ ;	North Voit		29b. Signature and title of certifier				29c. Li	icense numb	per		29d. Da	te signed (Mont	h, Day, Year)	
			" Newbuy	Mulan				2410	667		1	5. Le	1/0	
			30. Name and address of person who	completed cause of de	eath (Item 2	23a) (Type,	Print)	,		_		11	.1	
	Chai		Michael M 31. Date filed (Month, Day, Year)	10 (or mee	/c	[[[0 1	redi	201	(com v)	Mayer	bun	MO
	State Registra	~	JUN 04	completed cause of de Connec 32. Fégistra	s oignatu	8. 1	Barles							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 []] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 11, 2010 8:30 A M Elva Mae Tobery Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10314 Bridle Court Hagerstown Washington If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Nov. 23, 1939 1 M 2 X F Maryland Director 70 216-38-0365 Usual Residence of Decedent or 28a-f shov within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No <u>Mar</u>yland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 United States 10314 Bridle Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🖾 No If Yes, Give ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 X Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than * Elementary/Seconday (0-12) College (1-4 or 5+) Textiles 12 Factory Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Dora Hall Cooley Clifford Welty Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9029 Walter Martz Rd. Frederick, MD 21702 Jeffrey Wright / Son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 15, competery, crematory or other place)
Resthaven
Memorial Gardens May 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Frederick, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licenses Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mtn. Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease of complications that caused shock, or heart failure list only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Atherosclerotic Cardiovascular Disease Medical resulting in death) Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Dyslipidemia Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 X No
9 Unknown Pregnant at time of death Dav 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes completed filled in by the funeral director, Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \boxtimes Residence 6 \square Other (Specify) 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 🗌 No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 only one)

Box 68760

P.O.

Records,

Division of Vital

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Eugene B. Casagrande,

asulge

32. Registrar's Signature

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

29c. License numbe

M.D. 1564 Opossumtown Pike, Frederick, MD 21702

29d. Date signed (Month, Day, Year) 12 May 2010

10-03853 Charlene Frances	s U					ble.	1.0	, -, -
Division		1- For State Registrar 1. Decedent's Name (First, Middle,Last) Certificate of Death		2 Date	Reg.	No.	I U	3 Time of Death
Physicial Medical Examin		Charlene Frances Uphoff		Mon		ay Year 0		0153 hrs
		4a. Facility Name (if not institution, give street and number) Bowie Health Center 4b. City, Town, or Loca Bowie				Prince G	eorge	
Funeral Director		215-66-7860 _{1 M 2 F} 53 _{Yrs.} Months Days F	f Under 24 Hours			Asylle, Maryland 1 Home, Pasylle, Maryland 1 Home, Pasylle, Maryland 1 Home, Pasylle, Maryland 2 Home, Pasylle, Maryland 3 Home, Pasylle, Maryland 4 Winknown 4 Death 2 No 3 Probably 4 Winknown 5 Death 2 No 3 Probably 4 Winknown 6 Death 2 No 3 Probably 4 Winknown 7 No 3 Probably 4 Winknown 8 No 3 Probably 4 Winknown 9 No 3 Probably 4 Winknown 9 No 3 Probably 4 Winknown 1		
land f show any once.	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince George's Bowie						1 XYes 2 No
th the Mary 23a or 28a notified at	al Director	10e. Street and Number 12507 Caswell Lane 10f. Zip Code 20715				United	Sta	tes
fter death wi	/ Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes, Give Year 1 Yes 2 No	exican, Pue			White,	etc.	
2 hour	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) House keeper	(Give kind NOT use	of work don retired)				,
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than nigury or other traumatic event, the Medical	B	James Harold Uphoff Es	sther	Leon	e Ros	enthal		
, MD 21 and 2 should salth and Me em 27 is ma	잍	19a. Informant's Name/Relationship (Type, Print) Linda L. Uphoff -sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter	Green		Mary	land 20	770	
Itimore nit. Pages 1: artment of Hi ortant; If it		1 N Burial 2 Cremation 3 Removal from State MD Veterans Cemetery 4 Donation 5 Other Specify:	y 6/			heltenh	am,	Maryland
Physician	ļņ	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List only one cause on each line.	rgwar Mill h as cardia	dt Fui Road ic or respira	neral Belts tory arrest	Home, ville, , shock, or hear	PA <u>Mar</u> t	Approximate Interva
Avedical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Complications of 18Q-Syndrome Due to (or as a consequence of):				senthal er, City or Town, State, Zip Code) /land 20770 20c. Location - City or Town, State Cheltenham, Maryland L Home, PA Sville, Maryland20705 t, shock, or heart Approximate Interval Between Onset and Death		
	xaminer	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):					- 5	
0, t be executed sician and burnal - transi	шΙ	d. AMENDED AMENDED 23a, 27, per EM g905 7/22/10 TT	Γ					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	11 Living decades a second to the	ctopic pre	gnancy				ay Year
s, P.O. E uires that the c signed by the detached	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given	in Part I.	236			_	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death. The law requires that the sertificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral director, page 2 should be detacted in the funeral directory page 2 should be detacted in the funeral directory page 2 should be detacted in the funeral directory page 2 should be detacted in the funeral directory page 2 should be detacted in the funeral directory page 3 should be detacted in the funeral directory page 4 should be detacted in the funeral directory page 4 should be detacted in the funeral directory page 4 should be detacted in the funeral directory page 4 should be detacted in the funeral directory page 5 should be detacted in the funeral directory page 5 should be detacted in the funeral directory page 5 should be detacted in the funeral directory page 5 should be detacted in the funeral directory page 5 should be detacted in the funeral directory page 5 should be detacted in the funeral directory page 5 should be detacted in the funeral directory page 6 should be detacted in the funeral directory page 6 should be 6 sh	Completed			- _	a. Was an autopsy performe Yes 2	pr ed? de	ior to co ath?	mpletion of cause of
n of Vital I	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No 1. No 28a. Date of Injury 28b. Time of Injury 28c. Injury at 1.	er ₄ Nu	rsing Home	5 Re		, .	
VISION C or Attending ter death. irector: Aff in by the fun	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building	2 No	28f. Loc	ation (Stre	eet and Number		al Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Cert	4 Homicide determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dea		and due to t		s) and manner a		
To the Committee of the	Med	29b. Signature and title of certifier 29c. License nur O.C.M.E	mber		2	9d. Date signe	d (Mon	
		30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimor	ore, MD	21201				
Sta Registr		31. Date filed (Month, Day, Year) 32. Regisfrar's Signature						
DHMH 17 Rev 1/200 OCME 2006	_	ORIGINAL			- v			OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ulmschneider Physician/ Day 18 Month May Year Zo/O //:/D AM Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death Mai Baltimore Age (In yrs. last birthday) 5. Social Security Number 215 52 7603 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Month Day, Jan 25, Rhode Island Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Clinton 1 🗌 Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20735 8101 Woodyard Road 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No 19
If Yes, Give 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1967 Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 1978 Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail 12 Retail Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marguerite Gallant Otto Ulmschneider 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Ulmschneider (Wife) 8101 Woodyard Road, Clinton, MD Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State May 24,2010 Clinton, Maryland Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) neral S 22, Name and Address of Facility Lee Funeral Fone, Inc 6633 Old Alexandria . Signatu Ferry Road, Clinton, MD 20735 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 2 No the 9 Unknown page 2 should be detached Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar

Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jhitehur st

MAY 20 201

DHMH 17 Rev 7/2009

29d. Date signed (Month, Day, Year)

South Greene

Baltimore

18,2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death / Year Physician/ Mon 0520AM Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11417 Indigo Drive <u>Beltsville</u> <u>Prince Georae's</u> 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Hours Min. 1 🗆 M 2 🔽 F Mar 6, 1955 Virginia 224-78-9417 Director 55 Usual Residence of Decedent or 28a-f shov Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Calvert 1 X Yes 2 No Chesapeake Beach 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8098 Windward Key Drive 20732 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force 1 Never Married 2 Married Black, White, etc. Completed by ☐ Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Year or Dates White th and Mental Hygiene. 27 is marked other than "natur traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Assistant Vice-President Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew Arny Turner Edwards Frances Ann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Gottlieb/husband 11417 Indigo Drive Beltsville, Maryland 20705 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or otl 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 5/20/2010 Woodbine, Maryland 21. Sig phire of Funeral Service Reverly L. e Cremation Service P.O. Box 784 Heckrotte, P.A. Clarksville, MD 21029 M00957 Homes 23a. Part 1) Enter the disease, or complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on ea, h/ne. Approximate Interval Between Immediate Cause (Final Whiset and Beath aus Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): -transit Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 4 9 Unknown been signed by the should be detached 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an as 2 s autopsy page performed? Yes 2 No this certificate 1 Yes 2 No After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 00 Hospital Other: ျှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify Residence Manner of Death 1 Natural 2 Accident Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature And title of certifie 29d. Date signed (Month, Day, Year) sa. ne and address of person who completed cause of death 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	aryland / Depa	artment of I tificate of I		Mental Hy	giene			
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	uncate of i	Jeath	2. Date of Dea	Reg. No.	10	3. Time of Death	
П			Leonard Randolph	Waesch	e		Month	Dav	Year 2010		
			4a. Facility Name (if not institution, give street and number)	Macsell	4b. City, Town, o						
-	<i>*</i>		103 Woodland Avenue					Fred	erick	: 	
	Funeral Director		5. Social Security Number 220-18-1639 6. Sex 1 XXM 2 G F 7. Ag Usual Residence of Decedent	e (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days			y, Year 1927	9. Birthpl Countr Mar	ace (State or Foreign yland	
	faryland 8a-f show tified at	ector	10a. State 10b. County Maryland Frederick	10c. City, Town or Loc Thurmo					10d. Inside City Limits 1 ^X Yes 2 □ No		
	with the N s 23a or 2 ust be no	eral Di	10e. Street and Number 103 Woodland Avenue		10f. Zip Code 217	88		10g. Citizen of V USA	Vhat Count	ry?	
9800	ırs after death ural", or items I Examiner m		11. Marital Status 1 Never Married 2XXMarried 3 Widowed 4 Divorced 12. Was Decedent I Armed Forces? 1 Xyes 2 I Yes, Give 1 Year or Dates.	lf.	Yes, specify Cuba	an, Mexican, Pue	Specify Yes or No- erto Rican, etc.)		k, White, et	c.	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit once. Medical Certificate: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the Maryland bear and 2 should be detached for use as the burial-transit once. To the Hospital Or Attending Physician: The law requires that the Maryland or Sas-1 show and a spin of the funeral director, page 2 should be detached for use as the burial-transit once. To the Hospital Or Attending Physician with the Maryland or Sas-1 show and a spin or sas-1 show and	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 8	(Give A	rind of work done O NOT use retired)	during most of w	orking		•				
land 2	be filed wi ental Hygie ked other ic event, tl	Be	17. Father's Name (First, Middle, Last) Clinton F. Waesche	01711		18. Mother's N		Maiden Surname			
	Ø = Ø .		19a. Informant's Name/Relationship (Type, Print) Eileen Waesche – wife	19b. Mailin 103	g Address (Street Woodland	and Number or F Avenue	Rural Route Number	; City or Town, Si	tate, Zip Co land	21788	
more,	Page 1 an nent of He ant: If iterr iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		natory or other plac		Date 3-2010		-		
Balti	permit. Departr Imports any injt		21. Signature of Funeral Service License Marow (land 21702	
		/	23a. Part 1. Engly disease, or complications that caused shock, or leart failure. List only one cause on each line Immediate Cause (Final disease or condition				ac or respiratory arr	est,		Interval Between Onset and Death	
-		Je.	Sequentially list conditions b.		Ab. City, Town, or Location of Death Ab. City, Town, or Location of Death May 11 2010 10:52 P M						
	e executed ian and urial-transit		cause (Disease or linjury that initiated events c	a consequence of); a consequence of);							
	ate be ohysic the bu	dic	d						-		
Box 687	death certifii ne attending ed for use as	ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 1 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown	2 Fetal death 3 E		гу				•	
s, P.O.	ires that the signed by d be detacl	d by Ph	Part II. Other significant conditions contributing to death b	ut not resulting in the ur	nderlying cause giv	ven in Part I.					
ecord	he law requ te has been age 2 shoul	omplete					- autop perfor	sy p med? d	rior to com eath?	pletion of cause of	
al H	an: Th tificat tor, pa	e C	25. Was case referred to medical examiner?		26. PI	ace of Death (Ch		2 [X No] 1	☐ Yes 2	JEL No.	
ξ	hysic his ce I direc	요	1 ☐ Yes 2 🔏 No Hospital:	ent 2 ER/Outpatien	t 3 □ DOA Oth	er: 4 🗌 Nursing	Home 5 Resid	ence 6 🗆 Other	r (Specify)		
on of	ending Pl eath. or: After tl he funera	ficate:	27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident Investigation 3 Suicide 6 Could not be	ry 28b. Time of injury	work	?	28d. Describe he	ow injury occurre	d		
Divis	ital or Att urs after d ral Direct		4 Homicide determined 28e. Place of Inju- building, etc				City or Tow	n, State)			
	the Hosp hin 24 hol the Fune mpleted fi		(Check 2 — Medical Examiner: On the basis of e. only one) 3 — Certifying Nurse Practioner: To the	xamination and/or investi	gation, in my opinion eath occurred at the	on, death occurre e time, date and p	d at the time, date ar place, and due to the	nd place, and due cause(s) and mar	to the caus	e(s) and manner stated. ed.	
	5		29b. Signature and title of certifier		DO				,	ıy, Year)	
	HTIVA		30. Name and address of person who completed cause of d Mark Goldstein, M.D.	501 W. S		treet,	Frederick	, Maryla	and	21701	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registre	r's Signature	barker						

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Winter Patricia Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Allegany WMHS-RMC Cumberland 9. Birthplace (State or Foreign Country) MD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours 1 □ M 2 □**x** Mun 16 ^{ar}1929 229-32-9135 80 **Director** Usual Residence of Decedent il Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State within 72 hours after death with the Maryland Director MD Allegany Cresaptown 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 13501 Winter Lane 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 Yes 2 No If Yes, Give white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o Rose (VanMeter) Brown pe Joseph Brown permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number 13501 Winter Lane 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Winter Lane Cresaptown MD 21502 Louis Winter husband Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State Sunset Memorial Park 5/13/2010 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Mineral Service Lie nsee 22. Name and Address of Full Fruit Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Yes 2 No 9 Unknown s been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed 1 Yes 2 No After this certificate funeral director, pag 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending death. 24 hours after death. e Funeral Director. A pleted filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of phy knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 **Certifying Nurse** Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 6 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUMPERLAND, MD SETON DRIVE 924 VIKRAMADITYA POONALM.D.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			any County	State of Maryla per np, g904	.06/B4926T0		Mental Hy	9	17570
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, La 4a. Facility Name (If not institution, give	re street and number)		fisler III ity, Town, or Location of Dea	2. Date of Der Month O 5	Day Year O 9 201 4c. County of Dea	3. Time of Death 600 PM
	Funeral Director		5. Social Security Number 6. S 213-40-3835 Usual Residence of Decedent		rs. last birthday) If Un	der Year If Under 24 Hrs ns Days Hours Min		y, Year) C	thplace (State or Foreign buintry)
	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Director	PA 10b. County BEDF 10e, Street and Number		City, Town or Location YNDMAI	Zip Code		10g. Citizen of What C	10d. Inside City Limits 1 □ Yes 2 ☑ No ountry?
	ges 1 and 2 should be filed within 72 hours after death with the Marylan tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notifiled at	Funeral Di	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13. Was De	15545 cedent of Hispanic Origin? (specify Cuban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	USA 14. Race - Ame Black, Whi	
21215-0036	72 hours afte natural", or i lical Examir	þ	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's E (Specify only highest gr.	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: ducation ade completed)	16a. Decedent's U	s 2 No Specify: Isual Occupation work done during most of wo	orkina	Specify: \(\sqrt{1} \)	/HITE /Industry
	filed within Hygiene. other than " ent, the Mec	e Completed	Elementary/Secondary (0-12) 1 Z 17. Father's Name (First, Middle, Lasi	College (1-4or 5+)	life. DO NO	Tuse retired) 30 R E R		MANUFA C	TURING-
/lan	uld be Mental irked c	To Be	CHARLES F.	WISLER .	JR	MILL	DRED	M. KEN	INELL
e, Maryland	1 and 2 shoul Health and M em 27 Is marl hther traumati	·		I ISLER / BRO	135 MT	ess (Street and Number or F	HYNDM	AN PA 15	545
Baltimore,	t. Pa rtmen rtant: njury		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 ★ 4 □ Donation 5 □ Other (Special Control of European Service Lies	Removal from State	Place of Disposition (cemetery, crematory)	Name of or other place) NCEM. 5-1 and Address of Facility H		20c. Location - City on	IN PA
Ba	permi Depar Impor any ir		21. Signature of Funeral Service Lice	1. Dur		INC 169 CIG			
	Physician /Medical Examiner		23a. Part1. Enter the disease or comshock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the de one cause on each line. a. De Men Due to (or as a consi	tia	node of dying, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consect. Due to (or as a consect.) Due to (or as a consect.)					
P.O. Box 68760	w requires that the death certificate been signed by the attending phys should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome pf preg 1 □Live birth 2 □ Fe 4 □ Pregnant at time o 9 □ Unknown	etal death 3□Ectopi	c pregnancy (specify)		23d. Date of de Month	ellivery Day Year
	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	contributing to death but not re	esulting in the underlyin	g cause given in Part I.		obacco use contribute t Yes 2□ No 3□ F	
al Reco	The lar ate has page 2	Completed	Myocardial.	Enfarction			24a. Was autop perfo 1∐ Yes		
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othor: 6	eath <i>(Check only</i> o		
Ö	Physer this eral dil	۲. <u>ح</u>	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	T	dence 6 Other (Spe how injury occurred	ecify)
Division or Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	1 Natural 5	e 290 Place of injury - At	home, farm, street, fac	1 ☐ Yes 2 ☐ No	28f. Location (S	Street and Number or F wn, State)	tural Route Number,
	he Hospit in 24 hours he Funera pletely fille	Medical C	29a. Certifier (Check only one) Certifying Pi	nysiclan: To the best of my k miner: On the basis of exami and manner stated.	nowledge, death occur ination and/or investiga	red at the time, date and place tion, in my opinion, death occ	ce, and due to the curred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the complete of the complet	Ž	29b. Signature and title of certifier	/ 0		29c. License number		29d. Date signed (Mon	
	5		30. Name and address of person who	completed source of death (1)	em 23a) (Tune Brint)	12118578		05-10-8	3010
_	nes		Mill III Cala-	14614 Mansh	PIKE H	justiun n	1021	742	
	Sta Registi		31. Date filed (Month Day, Year) NAY 1 3 2010	32. Registrar's Sig	nature (J			

10-04001 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dennis W. Weddle, Jr. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Dennis Wayne Weddle, Jr. Month Day May 25, 2010 **Medical Examiner** 1545 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5802 Planters Court **Erederick** Frederick 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Months Day Hours Director 215-19-2348 couMaryland Sept. 15, 1978 1 XM 2 F 31 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Frederick Frederick 1 Yes 2 X No 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5802 Planters Court 21703 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Never Married 2 X Married 2 X No Yes Specify: White 1 Yes 2 No specify: 3 Widowed 4 Divorced f Yes, Give Year nt of Health and Mental Hygiene.

11: If item 27 is marked other than "natural", other traumatic event, the Medical Exminer ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Research Analyst Computers Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dennis Wayne Weddle, Sr. Pamela Duvall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rebekah J. Weddle, wife 5802 Planters Court, Frederick, MD 21703 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State Mount Olivet Cemetery June 1, 2010 Frederick, MD Donation 5 Other Specify. 5 Signature of Funeral Service ²². Name and Address of Facility Reeney and Basford PA Funeral Home 106 East Church St., M00255 Frederick, Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line. · /Medica Death Immediate Cause (Final disease <u>Difluroethane</u> intoxication Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause Enter Underlying Cause Due to (or as a consequence of). (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and or use as the burial - trar P.O. Box 68760, signed by the a Division of Vital Records, s been s has this certificate After within 24 hours after deam.

To the Funeral Director: A

Þ

Completed

Be

Medical

State

Registrar

23b. Was decedent pregnant in the 1 Live birth Fetal death Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 V No 3 Probably 4 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Other Nursing Home 5 Residence 6 🗹 Other Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 1 Yes 2 X No 5 Pending 5/25/10 Fd 3:30 pm 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 7 Planters Ct 3 Suicide 6 X Could not be found at home (Specify) Frederick, __ Homicide 29a. Certifier (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

27,28a-f,per ME g905 7/29/10 TT

23d. Date of delivery

May 26, 2010

23c. If yes, outcome of pregnancy

Assistant Medical Examiner

32. Registrar's Signature

Val. Bl. And

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

31. Date filed (Month, Dew Wear)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19 Day Physician/ 2010 May Tongfen Zhou 3:00 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 15170 Sapling Ridge Drive Dayton Howard 8. Date of Birth
(Month, Day, Year)
Sept 25, 1924 Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 🗆 M 2 🛣 Hours Director 85 Ch<u>ina</u> 151-94-2941 Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No Maryland Howard Dayton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r items 23a or iner must be n ō Funeral 15170 Sapling Ridge Drive United States Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene.

Fant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Asian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Professor Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Zhenyun Zhou Yuke Chen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edwin Jao/son 15170 Sapling Ridge Drive Dayton, Maryland 21036 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 5/21/2010 Woodbine, Maryland Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service M00957 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph. sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown for Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) မှ After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 X Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation the f 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 24 only one 29b. Signature and title of 164395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOUMPLES ST. SWIFE 4105 BALTIMOREIND 21204

Registrar

State

egistrar's Signature

10-03923 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael Christopher Aaron, State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death Physician/ 1. Decedent's Name (First, Middle, Last) Month Day May 22, 2010 1546 hrs Medical Examiner c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number **Baltimore County** 3601 Annapolis Road, Apartment A Baltimore If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) Social Security Number **Funeral** Foreian Months Days Hours Min. Director Country) 1 MM 2 5-93-612 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 1 Yes 2 No mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland partment of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 3003 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 2 1 No Yes WHITE 1 Yes 2 No specify: Specify: .3 Widowed 4 Divorced If Yes, Give Year þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than 2 17. Father's Name (First, Middle, Last) Be 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition, 27 MAJ1 27 Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: Signature of Funeral Service License Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and /Medical Methadone and alprazolam intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED 23a 27,28a-f,per ME g904 6/8/10 TT Division of Vital Records, P.O. Box 68760. attending physion for use as the bur 23d. Date of deliver IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Day Year Live birth 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed² death? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work' 28d. Describe how injury occurred Certification: Natural 1 Yes 2 No 5 Pending Director: Fd 3:41 pm Fd 5/22/10 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3601 Annapolis Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 X Could not be Suicide (Specify) found: private dwelling determined 24 hours Baltimore, Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 23, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Green Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per FH e904 6/14/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ P^{M} Carlo Alias 2010 June Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death County of Death Examiner 2917 Eastern Boulevard, Unit#19 Middle River Baltimore 5. Social Security Number 6. Sex 1**X** M 2 \square F If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Age (In yrs. last birthday, 8. Date of BirthFeb. 13 9. Birthplace (State or Foreign **Funeral** Days Months Month, Day Year) 2/15/1953 Maryland Director 213-64-8253 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Yes 2X No Middle River Maryland Baltimore 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with S. A. <u> 2917 Fastern Boulevard,Unit#19</u> 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces's Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other any injury or other trainment. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Trucking Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Emily Paddletti John Alias, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt "E" Cockeysville, MD 21030 John Alias, Jr. (Brother) Kings Crossing 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death) Maryland 21221 Approximate Interval Between Onset and Death Physician/ Medical Examiner equentially list conditions Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that the death certificate be executed and the bunial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Pregnant at time of death Yes 2 No the detached 9 Unknown 9 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by or Attending Physician: The law requires Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work' 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date 30. Name and address of derson who completed cause of death (Item 23a) (Type, Print) MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 07 2010 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 John Arthur May 3:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2964 Normandy Drive Ellicott City Howard If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) Funeral Country)
Maryland 1 🕅 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) 07/04/1947 Director 212-48-9875 62 Usual Residence of Decedent 28a-f show 10a State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Howard Ellicott City 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 2964 Normandy Drive 21043 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: d Mental Hygiene. marked other than "natural", Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Director of Parks & Rec. Public Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clara L. Arthur Μ. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 2964 Normandy Drive, Ellicott City, MD 21043 <u> Martha Arthur / Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 05/27/2010 Hanover, Maryland 4 X Donation 5 Other (Specify) 22. Name and Address of Facility ANATONY GIFTS PAGISTRATION 7500 CONSUED BY SIE & HANDUNY, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HERATORENAL disease or condition Medical resulting in death) Due to (or as a conse juence of): Examiner CLANGIOCARC cequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and the burial-transit SCLEROSING CHOLANGITIS Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Day Pregnant at time of death 1 Yes 2 No cate has been signed by the a page 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autonsy 2 X No 1 🗌 Yes Yes 2 X No Hospital or Attending Physician: 1 24 hours fter death. Funeral Trector After this certifica Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be 2 X No Hospital Other: 1 Yes ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 Natural injury 5 Pendina Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital of within 24 hours of To the Funeral D Medical 29a. Certifier 🗠 rtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the fline, date and place, and due to the cause(s) and namer as stand 29b. Signature and title of certific 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reactrar's Signature

Rosera

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ .40AM Medical Name (if not institution, give street and number **Examiner** Town, or Location of Death 4c. County of Death timore Year If Under 24 Hrs. If Under 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K Min. Months Days Director or 28a-f show aţ 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director be notified 1 es 2 No TIMOR 10f. Zip Code 10a. Citizen of What Country 23a Funeral "natural", or items 23a within 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Specify: 3 ₩idowed 4 □ Divorced Completed Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working aith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med DO NOT use retired) ary/Seconday (0-12) raria Be Baltimore, Maryland filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, permit, Page 1 and 2 should be file Department of Health and Mental I Important; If item 27 is marked o any injury or other traumatic eve Rural Route Number 19b. Mailing Address 20a. Method of Disposition 20b. Place of Disposition (Name of - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 21. Signature of Juneral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Abdomina Onset and Death Immediate Cause (Final Physician/ avanoma disease or condition nown Medical resulting in death) **Examiner** erous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury and as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician by Physician/Medical P.O. Box 68760 signed by the attending IF FEMALE: use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ò Month Day Year 1 | Yes 25 9 | Unknown page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform this certificate 0 1 🗌 Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I Hospital or Attending Physician: To Be Was case referred to medica 26. Place of Death (Check only one) Other: patien 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Prantioner T. It is basis of my normal great or military to the cause of the ca (Check within 2 To the or by une 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) me and address of person who completed cause of death (Item 23a) (Type, Print) ate filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

0

17577

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Two 9:55 PM 200 Stephen Blanton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner AGNES BALTIMORE SAINT HOSPITAL NA If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1/26/ **Funeral** Months Days Min. Hours 1 X M 2 □ F 60 Director North Carolina 241-76-4369 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, It's Modical Examiner must be notified at W∏Yes 2 ☐ No Director NA MD Baltimore 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 523 Normandy Avenue 21229 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Black, White, etc. African Armed Forces?

M☐Yes 2☐No
If Yes, Give
Year or Dates: Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: 2 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Education 12th Grade Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James W. Blanton ပ Juanita Boger 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beulah Richardson <u>523 Normandy Ave. Baltimore MD. 21229</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6/10/2010 4 ☐ Donation 5 ☐ Other (Specify) National Cemetary Salisbury, N.C 22. Name and Address of Facility Wylie Funeral Homes, P.A. 21. Signature of Funeral Service Licensee 638 N. Gilmor Street Baltimore Md. 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Jailme Immediate Cause (Final Days Hepatic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Colon Cancer Examiner work Metastatic Sequentially list conditions, if any, leading to innihedrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed burial-transi and Due to (or as a consequence of) Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, b E Coli sepsis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ▼No 24a Was an has page 2 s autopsy performed? Yes 2 No certificate Vital 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ oţ After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? ne Hospital or Attending Property of 24 hours after death.
The Funeral Director: After the fetely filled in by the funeral 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Division 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P24069 C.M June, 2, 2010 Hloing lint 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HLAING TINT, 900 Caton Ave Baltimore, MD ,900 Caton

DHMH 17 Rev 1/2001

State Registrar

E PH

LS

BLANTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 30 2010 11:01A M Tyrone Bates May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Apt.B-2 2382 Seamon Avenue Baltimore If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. 6. Sex. 1 X M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year, 6 - 25 - 5) 59 Director MD 218-46-8991 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director or 28a-f sh notified 1 ¥ Yes 2 □ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a on any injury or other traumatic event, the Medical Examiner must be a Completed by Funeral USA 2382 Seamon Avenue Apt."B-2 21225 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. African 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: American 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) South Baltimore Elementary/Seconday (0-12) 12th Grade $\stackrel{\text{College (1-4 or 5+)}}{NA}$ Family Health Ctn. Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robinson Shirlev George Bates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2927 Vermont Avenue Halethorpe, MD 21227 Mustafa Bates-Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State emorial Park 6/3/2010 | Randallstown, M 22. Name and Address of Facility Wylie Funeral Home P.A. 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 6/3/2010 21, Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HUPER TENSION Immediate Cause (Final Physician/ disease or condition resulting in death) Medical 6 NO SCLENS IS -CALDIOVASCULAR **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the Inneral director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an was a... autopsy performed death? 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 🗌 No Investigation
6 Could not be Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR g904 67//10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ Lackey 903 AM Margaret Billington -2010 Medical 4a. Facility Name (if not institution, give street and numbe 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia Howard 8. Date of Birth (Month, Day, Year) 05/06/1939 Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🔽 F Months Hours 213-36-5631 71 Director Arizona Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State death with the Maryland Director MD Baltimore Linthicum Heights 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21090 6219 Groveland Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. Yes 2 No and Mental Hygiene. is marked other than "natural", or 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes X ☐ No Specify: White If Yes. Give Specify: Completed 3 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Assistant/Medical Medical Billings Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Flora Trevitt Orval Ray Allen permit. Page 1 and 2 should be Department of Health and Men: Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6219 Groveland Road, Linthicum Heights, MD 21090 Mr. Gary L. Lackey (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) MD Veterans-Garrison | 06/10/2010 | Owings Mills, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician intra - abdominal infection Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of, Exami attending physician and for use as the burial-transit equires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death catchas teen signed by the pege 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown preumonia Records, Completed 24b. Were autopsy findings available 24a. Was an Hospital or Attending Physician: The law '24 hours after death.
 Funeral Director: After this certificat, has t prior to completion of cause of death? autopsy performed 1 Yes 2 INO Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA ည 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural work' 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 100665IT Coval Jun 02 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 10710 Charter Drive Suite 310 Columbia, MD 21044 Nishi Rawat, 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State 2010 **>** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (1): (1)

			For State Registrar	Otate of Mary		tificate of L			leg. No.	i U	101	OU
6	Physici	an	1. Decedent's Name (First, Middle, La	st)	D			Date of Dea Month	Day	Year	3. Time of De	
1	/Medic	al	Gertrude 4a. Facility Name (If not institution, glv	e street and number)	376	4b. City, Town, or	Location of Death	Mary	2 4 c. Coun	ty of Death	5 001	72
	Examin	er	The Johns Hopkins H			Baltimore		•		N/A		
	Funeral		5. Social Security Number 6. S		yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day	Year)	9. Birthp Count	place (State or F try)	oreign
	Director		240-40-3000	8!	5 Yrs.			April1	0,192	5 N.	Caroli	na -
	land ow		Usual Residence of Decedent 10a. State 10b. County		c. City, Town or Loc					1	0d. Inside City	
	Mary a-f sh fied a	ctor	MD Balt	timore	Pā	arkville	9				1 Yes 2	X No
	ith the or 28 e noti	Dire	10e. Street and Number			10f. Zip-Code		1	0g. Citizen of		try?	
	s 23a	eral	2868 Aspen Hil		12 116		234	oifu Vee or No.		ISA ace - Americ	an Indian	
36	I be filed within 72 hours after death with the Maryland and Hygiene. And Hygiene. Gother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes XXO If Yes, Give Year or Dates:		Yes, specify Cuba	lispanic Origin? (Spean, Mexican, Puerto F Specify:	Rican, etc.)	ВІ	lack, White, o	etc.	
Maryland 21215-0036	hin 72 hou e. an "natura Medical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4 or 5+)	(Give I	OO NOT use retired	during most of workir f)	ng	16b. Kind of	Business/In	dustry	
21	er the	Con	6th Grade		Fost	er Pare	18. Mother's Name	(First Middle	Maidan Sura	amal		
pu	be file Ital Hy od oth event	Be	17. Father's Name (First, Middle, Last) Henry Bryant	1			Floren			anie)		
Z Z	12 should be f n and Mental H is marked oi raumatic ever	ပ	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	g Address (Street	and Number or Rura			n, State, Zip	Code)	
Ma	nd 2 s Ith an 27 Is :		Sharon R. Seymo	ore/ Daugh	ter 2868	3 Aspen	Hill Ro	ad Par	kvill	e, M	D 2123	4
ē,	ss 1 ar		20a. Method of Disposition XXBurial 2 Cremation 3		20b. Place of Dispo	sition (Name of natory or other place	D D	ate	20c. Location	n - City or To	own, State	
<u>E</u> .	Page nent c ant: If ury or		4 Donation 5 Other (Speci	fy)			em. 5/29				le, Md	
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic es		21. Signature of Euneral Service Licer	to ares	42	210 Bela	ess of Facility Chair Road	Balti	more,			Home
	150		23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ente	er the mode of dyin	ng, such as cardiac c	or respiratory ar	rest,		Approximate Interval Betwee Onset and De	
	hysician		Immediate Cause (Final disease or condition resulting in death)	a. Puppire		عرر هاي	itic ano	ache	~			
	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):							
	ed sit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to or as a co	onsequence of:							
D.D.	ificate be executed g physician and as the burial-transit		that initiated events resulting in death) Last	Due to (or as a co	onsequence of):							
68760,	tificate be ig physici as the bi	Medical		d							_	
×	hat the death certific od by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	y			Date of delive Month	ery Day Ye	ar
P.O.	at the by the	Phy	9 Unknown		ent requiting in the .	underhing souss a	ivon in Part I	230 Did to	phaceo use co	ontribute to t	the cause of de	ath?
rds, I	law requires that the as been signed by the 2 should be detache	þ	Part II. Other significant conditions	contributing to death but n	not resulting in the t	enying cause g	en in Fait i.	1 🗆 1			pably 4 5	
Ö	> 0 0	Completed						24a. Was a	an 24	b. Were auto	opsy findings av	/ailable use of
E.	The laste has page	Com						1 Tes	rmed?	death?		
/ita	sician: The lav certificate has irector, page 2	Be (25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Death					
of	ξε is p	6	1 Yes 2 No 27. Manner of Death	1 inpatient	2 ►ER/Outpatien 28b. Time o	1 3 LI DOA	4 - Nuising noi	ne 5 Resid			δy)	
on	ding the	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	ar) Injury	Wor	k? Yes 2 □ No					
Division of Vital Records,	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funera	Certification:	3 Suicide 6 Could not I 4 Homicide determined		At home, farm, stre Specify)	eet, factory, office	4	28f. Location (3 City or Tow		mber or Rur	al Route Numb	er,
	Hospita 24 hours Funeral letely fille	Medical C	29a. Certifier (check only one)	hysician: To the best of m miner: On the basis of exa and manner stated	amination and/or in	occurred at the tile vestigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) and date and plac	manner as s ce, and due	stated. to the cause(s)	
	To the within To the complete	Me	29b. Signature and title of certifier	1		29c. Licens			29d. Date sig			
			•	UT !	MD	re	5-000		From	24,	2010	
	5		30. Name and address of person who	O TI			600 1	lorth Ma	Ifa St E	Raltimo	re, MD, 2	1227
	Sta	et o	31. Date filed (Month, Day, Year)	32. Registra's	1 1	D	1 000	AOITH WO	ile Ol, E	aitiiiii	. C, IVIU, Z	.1201
	518	H.	HIN 0 & 2010	Clares a M	MARKEN							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 05 2010 0240 Bronson Braun Berenbrok 1)6 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rosodale Square th mor (enter ·n If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 6. Sex **Funeral** Year Hours Maryland Months Davs 1**X** M 2 □ F 220 18 8421 83 Jan. 31, 1927 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinat must be notified at Baltimore 1 ☐ Yes 2 X No Director Maryland Essex 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 278 Montrose Avenue 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 🛛 No Specify: White WW II 9 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) be filed within Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Police Officer Baltimore, County Gov. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Edward Victor Berenbrok Mildred A. Rawlinson ဥ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) of Health Frances B. Berenbrok 278 Montrose Avenue Baltimore, Maryland 21221 other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory Inc. 6/7/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ²² Name and Address of Facility Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signature of Funeral Service License Approximate Interval Between Onset and Death 23a. Pat1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Immediate Cause (Final aborge left subdural hematoma + Subarachnoid
__nue to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examine relate rauma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and the burial-tran Due to (or as a consequence of) physician Physician/Medical attending p use as IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) the detached 9 ☐ Unknown 9 Unknown by signed by be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given art I. 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a Was an has autopsy performed? 1 □ Yes 2 🗓 No page certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be aminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Injury 1 | Natural tell from bed 1 ☐ Yes 2 No 4:30 A r death. 2 Accident 6/01/10 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 278 Montrose Ave Batte MD 31201 Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and m nner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

law requires that the death certificate be executed Box 68760. P.O. Division of Vital Records, The Physiclan: or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the the Hospital

Baltimore, Maryland 21215-0036

State Registrar 29b. Signature and title of pertifier

31. Date filed (Month, Day, Year)

תנוחו

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Neil Rosenman, 9000 Franklin Squ

29c. License number

E500000

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Christina Dianne Busson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Christina Dianne Busson Month 0641 hrs **Medical Examiner** June 3, 2010 4a. Facility Name (if not institution, give street and number) c. County of Death 4b. City, Town, or Location of Death Columbia 8371 Tamar Drive Howard 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Days Hours **Director** 215-92-8516 1 M 2 X F 37 April 6 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State MD Howard Columbia 1 Yes 2 No 28a-f show within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8371 Tamar Dr., Apt. 734 21045 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 v Never Married 2 Married 1 Yes 2 X No 3 Widowed 1 Yes 2 X No specify: 4 Divorced f Yes. Give Year Specify: white ≥ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry narked other than "natur Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 2 sales clerk retail sales 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Be Donald Gene Busson Carol Ann Gerstenslager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald G. Busson (father) 1583 Thunderbird Rd., Hesperus, CO 81326 Σ 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) t: If i 1 Burial 2 X Cremation 3 Removal from State Important: injury or oth All County Cremation 6-7-10 Sykesville, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee C trainformate Box 195 Sykesville, P.O. MD 21784 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and /Medical Death Seizure disorder Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of). Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed hysician/Medical X UNPENDED AMENDED 23a,27,28a-f,per ME g905 7/22/10 TT attending physician or use as the burial 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy 1 Live birth Day Year Fetal death Month past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown Unknown The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ö <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed' death? 1 🗸 Yes page ✓ Yes 2 No 2 No the Hospital or Attending Physician: Vital 25. Was case referred to medica 26.Place of Death (Check only one) Be Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes of o 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 1 Yes 2 X No Director: Pending subject fell from horse unk unk 2 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be within 24 hours a To the Funeral I determined (Specify) unk 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. June 3, 2010 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registra UIN 0.7.2010

DHMH 17 Rev 1/2001 **OCME 2006**

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 7:05 PM Sebastian Bittorf May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 54 Murdock Road Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗆 F Months Days Hours Min. (Month Day Year) 07/06/1950 Maryland **Director** 214-56-7208 59 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 54 Murdock Road 21212 U.S.A. 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 2 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sebastian Bittorf, Sr. **Emma** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Bittorf / Wife 54 Murdock Road, Baltimore, MD 21212 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 05/27/2010 4 Donation 5 Other (Specify) Anatomy Gifts Registry Hanover, Maryland 21. Signature of Purplyal Service Licenses 22. Name and Address of Facility ANATOMY GIFTS REGISTRY 7582 counciley DR. STE P. HANDISK, MD 23a. Part 1. Enter the disease, or complications the treased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ lioblastoma 300 disease or condition resulting In death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Day Pregnant at time of death 5 Other (specify) Year the a signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 ☐ Yes 2 → No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s performe **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 2 No 1 Inpatient 2 KER/Outpatient 3 I DOA funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number m 28258 05-27-2010 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address John Hopkins Hospitel ohn aterra

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Resistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** MARIE ANTOINETTE CUNEO JUNE 2010 5:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1102 GREEN ACRE ROAD TOWSON BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea 1/3/1913 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☐ M 2X F 216-05-6936 Yrs. Director MARYLAND Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir then "natural", or itams 23a or 28a-f shov the Medical Examinar is ust be notified at 1 ☐ Yes 2 ☐XNo Director MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1102 GREEN ACRE ROAD 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 2 should be filed w and Mental Hygier is marked other th 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked ieny injury or other treumatic eveny injury or other treumatic eveny. JOHN GROB THERESA ESPOSITA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANDREW CUNEL/SON 1102 GREEN ACRE RD. TOWSON, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
MOST HOLY REDEEMER Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/9/2010 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD CFMETERY
22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOO2 17 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) OSION /Medical Due to (or as a consequence of): Examiner Breast Cancer Mastectami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed burial-transit attending physicien and that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day Year 4☐Pregnant at time of death 5 Other (specify) Records, P.O. be detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 210 No 1 ☐ Yes Division of Vital Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 1 ☐ Yes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □Other (Specify) 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After Certification or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: filled in by the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Direct 4 Homicide To the Hospitel 29a. Certifier 🕰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal West Certifying Physicien: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 ☐ Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Willy MO Ww 1000 55301 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4501 North Charles Street Suit 500 Towson, MD 21204 Myint MO Khin Win

State Registrar

JUN 0 7 2010 >

31. Date filed (Month, Day, Year)

32. Registrar Signature
10 Deneura S. Jawa

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 6 Physician/ (ameron Day Calonger 6:35 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Season's Hospice@Northwest Hospital Baltimore If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number 8. Date of Birth **Funeral X**□ M 2 □ F Days (Month, Day, Year) **Director** 213-32-6063 1935N.Carolina Usual Residence of Decedent or 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director N/A1 XYes 2 No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3825 W. 21215 USA Rogers Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 √2 Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 🛠 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Steelworker years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Cameron Rosa Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3825 W. Rogers Ave Baltimore, Maryland21215 Yvonne Barber/ Companion 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Garrison Forest Vet. Cem. Dwings Mills,MD 22. Name and Address of Facilithatman-Harris Funeral Home Signature of Funeral Service Licer \$240 Reisterstown Rd Baltimore, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he failure. List only one cause on each line. Immediate Cause (Final Atheroscierotic Curdiovascular Disease Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions if any, leading to immediate Examine Due to (or as a consequence of) it any, leading to introduce cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Hospital Other: in part ent hospice 4 Nursing Home 5 Residence 6 Other (Sp. 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 🗌 Pending within 24 hours after acc.

To the Funeral Director Aft 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSKajapahnem.D 6/2/10 D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N. S. Rajapa KSE, M.D. 2835 Smill N. S. 235 - Baltimore, M.D., 21209

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAPUTH 25ay 20°£0 Ceballos 7:27P. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c, County of Death 11805 Meadowland Drive Bowie Prince George's 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Days Hours Months Apr. 30° 1923 87 C8Tombia **Director** 462-57-4267 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Bowie Direct 1 X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11805 Meadowland Drive 20720 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married ş Baltimore, Maryland 21215-0036 1 XYes 2 □ No Specify: Colombian Specify: White If Yes. Give 3 Divorced 4 Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 is and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (154 pr 5+) Pastor SDA Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Alberto Ceballos Dolores Araujo de Ceballos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i Mario E. Ceballos -son 11805 Meadowland Drive Bowie, Maryland 20720 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of I-Important; If ite any injury or ot 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Metropolitan Crematory 6/02/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 21. Signature of Funeral Service Licenses Bonald V: Borgwardt Funeral Home, PA Would URS. 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ End Stage Renal Disease Medical resulting in death) Due to (or as a consequence of) Examiner Hypertensive Atherosclerotic Cardiovascular Disease Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Year ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Dementia; Quadriporosis dvc to spinal stenosis Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been si should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has the lirector, page 2 s autopsy performe Yes 2 X No 1 ☐ Yes 2 🗓 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 🗌 Yes 2 XNo 일 1 Inpatient 2 ER/Outpatient 3 IDOA this 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) work? within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D26564 May 27, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6 Susan Ginsberg, M.D. 106 Irving Street, #304 N.W. Washington, D.C. 31. Date filed (*Month, Day, Year*) **JUN 0 4 2010** State

DHMH 17 Rev 7/2009

THE PER

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month 5 Year Physician/ 10:450 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Catonsville Baltimore Renaissance Gardens Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Aug • 21, 7. Age (In vrs. last birthdav 9. Birthplace (State or Foreign **Funeral** Year 1914 Days Hours Month: 214-01-0891 Yrs Maryland Director 95 Usual Residence of Decedent shov 10a. State 10b. County ortant. If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 709 Maiden Choice Lane 225N 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Retail 12 Telephone Operator Be permit. Page 1 and 2 should be filed or Department of Health and Mental Hyg Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Sarah Claggett Francis O. Boarman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Lee Drive; Catonsville, MD 21228 Niece Barbara M. Boarman Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Buriai 2 Cremation 3 Removal from State Loudon Park Cemetery 6/1/2010 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of CatonsvIlle, Inc. 21. Signat e o Funeral Servi any 630 Edmondson Avenue; Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Acute oruna disease or condition **Medical** resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that better the cause of t Examine Due to (or as a consequence or) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an , page 2 s autopsy performed After this certificate funeral director, pag 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury e Funeral Director: Aft work 1 Tyes 2 🗆 No Accident Investigation 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maiden choice 711 Bowlin Registrar's Signat State

DHMH 17 Rev 7/2009

Registrar

10-04137 Jaeden Q. Dulin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Marvland / Department of Health and Mental Hygiene

		1- For State Registrar	Ce	ertificate of D		a ivicitai i		eg. No.	1,000
Physic		Decedent's Name (First, Middle,Las	D 7 12				2. Date of Deat Month	th Day Year	3. Time of Death
Medical Exam	ıner	4a. Facility Name (if not institution, give	a street and number)	1	City Town or	Location of Deat	May 30, 20	010 4c. County of Dear	2118 hrs
		Johns Hopkins Hospital	,		altimore			,	
Funeral Director		Social Security Number 6. Se		-	f Under 1 Yea			th(MM/DD/YYYY) 9. B Fore	ign 1.
— -		216-65-7671 1 Usual Residence of Decedent	M 2 F	Yrs.			11-24	f-2002_°	ountry) 1
any		10a. State 10b. County	10c. City	y, Town or Location					10d. Inside City Limits
Maryland 28a-f show d.at.once.	ō	MD		altin	ore				1 res 2 No
e Mary or 28a- fied at	Director	10e. Street and Number	200 - N	10 7	Of. Zip Code	112	10	Og. Citizen of What Cou	untry? ▲
0036 within 72 hours after death with the Maryland giene. Medical Essaniner must be notified at once.		11. Marital Status	12. Was Decedent Ever in U				pecify Yes or No-		rican Indian, Black,
r death or iten	Funera	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No	If Yes,	specify Cuban	, Mexican, Puerto	o Rican, etc.)	White, etc.	21- 10
rs after ural",	by	Widowed 4 Divorced 15. Decedent's Education (Specify or	If Yes, Give Year or Dates:	1 Yes	A		work done	Specify: 16b. Kind of Business	/Industry
136 hin 72 hours afte e. than "natural", edical.Examiner	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			DO NOT use ret			n /
003(within giene. ner tha	dmo	47 5 1 1 1 1 1 1 1 1		5	tud	ent	450 4 540 10 5	Stud	est
Dre, MD 21215-0036 es 1 and 2 should be filed within 7 of Health and Mental Hygiene. If liem 27 is marked other than ther transmatic event, the Medical the Medical Control of the Medi	Be C	17. Father's Name (First, Middle, Last)	1.1.0			18,Mother's Name	e (First, Middle, M	Maiden Surname)	'C
21, hould b id Men is marl	ToE	19a. Informant's Name/Relationship (T	/pe, Print)	19b. Mailing Ad	dress (Stree	t and Number or	ural Route Num	ber, City or Town, Stat	e, Zip Code)
, MD and 2 sho salth and em 27 is		20a. Method of Disposition	y (Grandmott	Hace of Disposition	7 C	est H	erights	Balto 1	1021215 r Town, State
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after neat of Health and Mental Hygiene. The start I fitem 27 is marked other than "natural", or other traumatic event, the Medical Essamine.		1 Burial 2 Cremation 3	Removal from State	crematory or other p		C . 6	5/200	Baltin	
Baltimore, permit. Pages 1 a Department of He Important: If ite	1	Donation 5 Other Specify: Onature of Funeral Servi License	Va	de of	and All ress	Denther of	J. J.	Day III	Servine)
	(S	1012	84	Ver	105	VOIR I	BO	Jto Mo	31212
Physician /Medical	2 0	23a. Part I/Enter the disease, or compl failure. List only one cause on ea	ch line.	n. Do not enter the m	ioae or aying,	such as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Pro 100 1 1 100 1 1	Head Injuries Due to (or as a consequence d	of):					354
	F	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	nfl·					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated c.							
uted nd ransit		events resulting in death) Last d.	Oue to (or as a consequence o	or).					
760, icate be executed sphysician and the burial - transit	Medical	UNPENDED	AMENDED						
8760, ificate be ug physic sthe bur		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of preg	gnancy 2 Fetal de	eath 3	Ectopic pregna	ancv	23d. Date of deliver	y Day Year
Box 687 e death certifice the attending ped for use as th	Physician/	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at time of de	noth =	(Specify)				,
that the death certificate by the attending detached for use as to	Phy	Part II. Other significant conditions	9 Unknown contributing to death but not r	esulting in the under	rlying cause g	iven in Part I.	23e. Did tot	bacco use contribute to	the cause of death?
ires that the signed by the detache	d by		_				1 Yes	2 No 3 Pro	bably 4 Unknown
ords aw requi nas been 2 should	ompleted	_					24a. Was a autops		utopsy findings available completion of cause of
Reco The laricate ha	Com						perform 1 ✓ Yes 2	med? death? ? No 1 ✓ Y	es 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?	ospital: 1 🗸 Inpatient 2	ER/Outpatient 3		of Death (Check		Residence 6 Othe	
n of V Jing Phys After thi funeral d	7: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Injury		y at Work?	28d. Describe h	ow injury occurred	
ion ttendir death.	atio	1 Natural 5 Pending 2 Accident Investigation	May 30, 2010	1821 hrs	1 Y	es 2 🗸 No	Passenger ir	nvolved in collisio	n
Division of Vital Records, pital or Attending Physician: The law requinuar after death.	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injury - At h (Specify) Major Roa		ctory, office bu		or Town, St		ural Route Number, City
Hospit 24 hour Funers		4 Homicide	in: To the best of my knowled		at the time, da				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 buts after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner:	On the basis of examination a and manner stated.	and/or investigation, i			at the time, date a		
	Σ	29b. Signature and title of certifier	11		29c. License O.C.N			29d. Date signed (Mo May 31, 2010	nth, Day, Year)
		30. Name and address/of person who c	ompleted cause of death (Item	n 23a)	3.3.				
		Jack Titus MD. Deputy C	hief Medical Examine	r 111 Penn S		imore, MD 21	1201		
S Regis	ate	31. Date filed (Month, Day Year)	010 32. Registrar's Signatu	J. par	Kel				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Ida Pearl Glascoe 10:30 AM May 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F Months Days Hours Min. (Month, Day, Year) 238-46-8229 Director 1.933 Carolina Usual Residence of Decedent shov 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland Director or 28a-f sl Farmville 1 Tes 2 No N.Carolina 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funera 4386 Wallace Street 27828 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examinar mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: SpeciBlack 3

Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Marriott Corp Cook 12th grade 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) မ Randolph Lucas Martha Boyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerette Atkinson-Vicks Neptune Court Somerset, New Jersey 08873 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Nat.Mem Laurel, Maryland Signature of Funeral 22. Name and Address of Facility Chatman-Harris Funeral Home <u>5240 Reisterstown Rd Baltimore, MD 21215</u> I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Daath mediate Cause (Final Physician/ Multiple Medical resulting in death) ue to (or as consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 **X**No Hospital Other: 1 Yes မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) the Hospital or Attending Natural injury 5 Pendina 1 Natural 2 Accident after death. 1 Yes 2 🗆 No Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours a 29a. Certifier 1 🚣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) Sasal AT- 243 8946 May 31, 2010

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PARDAD Sara5chu*

PARDAD

31. Date filed (Month, Day, Year)

Union Memoria

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month June GOLDMAN 4b. City, Town, or Location of Death 4c. County of Death HMORE N/A

1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 50 PAUL Medical 4a. Facility Name (if not institution, give street and r Examiner TIMOR 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 POLAND **Funeral** 8. Date of Birth Days 1**X**□ M 2 □ F Hours Min 0672271922 Director Yrs. 213-30-7416 87 Usual Residence of Decedent 28a-f show 10a. State 10b. County ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE BALTIMORE 1 ☐ Yes 2 X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8911 REISTERSTOWN ROAD 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2XX No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2XX No Specify. Specify: Completed 3 X Widowed 4 □ Divorced Goldman, Paul 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Should be and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) TAILOR CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ELEAZOR GOLDMAN ROSE UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau MORRIS GOLDMAN/SON WOODSYDE PLACE OWINGS MILLS, MD 20b. Place of Disposition (Name of LUBAWITZ^{na}NUSACH^{ola}ARI (NER TAMID) CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/04/2010 ROSEDALE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ mai disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy certificate 1 ☐ Yes 2 ☐ No Yes 2 W No completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify After this 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: A 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of certifie 29d, Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print)

State Registrar ot

Registrar's Signature

MA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Per inferes 1188 30-11 Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 5-26-2010 Physician/ Zakariya Abdul Qawi Hakim 6:55p Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 2927 Woodland Ave Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Days 1**X** M 2 □ F 56 Hours Min 8-18-1953 212-60-6698 Director Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits must be notified at Director Md. Baltimore 1X Yes 2 □ No 10e Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral , or items 23a 2927 Woodland Ave 21215 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian the Medical Examiner Armed Forces? Mar. 2 Black, White, etc 1 Never Married 2 Married ģ Maryland 21215-0036 If Yes, Give 1972 Year or Dates. Specify: Black 1 Yes 2X No Specify. "natural", 3 Widowed 4 Div Completed 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cosmetology Barber 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred H. Gordon Ruth Haskins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Maxine Woods - Sister 2021 Woodbourne Ave, Baltimore, Md. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place Garrison Forest 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🙀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6-3-2010 Owings Mill, Md. 21. Signature of Funeral Service Lice 22. Name and Address of Facility 411 Kennedy St, N. W. a Universal Mortuary Inc, Wash, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ End stage unknown adenocarinoma with Metas disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Wks Cardiac tampord With Chest tube Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Deep venous thrombosis wks the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical yrs Hypertension or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death signed by the at d be detached fo by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Spine stenosis, Depression 1 Yes 2 No 3 Probably 4X Unknown Completed Hepatits Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 death? certificate 1 🗌 Yes 2 XNo director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 XResidence 6 Other (Specify) 1 Yes 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 XNatural 5 Pending death. 1 Yes 2 No ☐ Accident the Investigation within 24 hours after deat To the Funeral Director; ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 L 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) D54749 June 1, 2010 30. Name and address of person who completed cause of deal tem 23a) (Type, Print) 304 Baltimore Ave, Beltsville, Maryland Allen Reilly, M.D. 31. Date filed (Month, Day, Year) Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State o	of Marylan		artment (<i>tificate</i> (giene Reg. No.	4010	17592
	.	,	Decedent's Name (First, Mid	dle, Last)						2. Date of De	oth		3. Time of Death
	Physicia Medic		JACK K	HOSKINS						Month &	Day	4 7010	1052 PM
	Examir	er	4a. Facility Name (if not instituti	· ·	,		"	vn, or Locatio			4c.	County of Death	
*	Funeral		UNIVERSITY OF N 5. Social Security Number	MARYLAND M	7. Age (In yrs. la		If Under 1	MORE If Und	der 24 Hrs.	8. Date of Birt	th	N/A	place (State or Foreign
	Director		218-38-4001	1 🗓 M 2 🗆 F	66	Yrs.		ays Hour		1 Month Da	1943		RIDA
	, wc		Usual Residence of Decedent							1 , , , ,	.,.,		
	ryland I-f sh	cto	10a. State 10b. Coun		10c. City	y, Town or Lo						i	10d. Inside City Limits
	or 28a	Director	MD B.	ALTIMORE		TOWSO	10f. Zip Co	ndo.			10 04	zen of What Cou	1 Yes 2 XNo
	with the 23a c		215 STANMORE	ROAD				1212				JSA	ntry ?
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho r the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S		Vas Decedent	of Hispanic	Origin? (Sp	ecify Yes or No-	·	14. Race - Ameri	can Indian,
36	ifter d ", or i	by	1 Never Married 2 X M	If You City	2 X No		f Yes, specify	_		Rican, etc.)		Black, White,	etc.
Ö	ours a atural	Completed	3 Widowed 4 Divorce	Year or Da				<u>'</u>					ITE
<u>τ</u>	72 h un "na Medic	mple	(Specify only hig	lent's Education hest grade completed)		(Give i	lent's Usual O kind of work de O NOT use ret	one during m	ost of work	ing	16b. Kii	nd of Business In	dustry
21215-0036	within giene. er tha		Elementary/Seconday (0-12)	College (1 2 YEARS	-4 or 5+)	1	SALESMA	,			REC	CORDS MA	NAGEMENT
2	filed al Hy d oth event	Be c	17. Father's Name (First, Middle	, Last)				18. Mc	ther's Nam	e (First, Middle,	Maiden S	Surname)	
yla	should be filled within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	P.	LANE C. HOSK					L	UCILL	E KEITH			
Maryland	475	3	19a. Informant's Name/Relation			1						Town, State, Zip	Code)
	1 and of Heal item 2	1	MAGDALENE HOS 20a. Method of Disposition	KIND/WIFE	20b. P		STANMOR sition (Name o	_		WSON, MI	-	1212 cation - City or To	own State
altimore,	permit. Page 1 Department of Important: If is any injury or c		1 ☐ Burial 2X☐ Crematio 4 ☐ Donation 5 ☐ Other		State C	emetery, cren	natory`or other EMATOR:	place)	l	7/2010		ONSVILLE	
alti	permit. F Departm Importa any inju once,	- 1	21. Signature of Funeral Service				. Name and A						OME, P.A.
m	9 3 E 6	5			•		521 LO		EN BL	VD. TO	WSON.		286
			23a. Part 1. Enter the disease, shock, or heart failure. Lis	or complications that of t only one cause on ea	aused the death ch line.	n. Do not ente	r the mode of	dying, such	as cardiac (or respiratory arr	rest,		Approximate Interval Between
	Physician/ Medical	5 1	Immediate Cause (Final disease or condition resulting in death)	_ a Intr	acrania	hemo	mhage						Onset and Death
	Examiner		resulting in death)	Due to (or as a consequ	ence of):	J						
		ner	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as a consequ	ence of):							
	d d ansit	Examiner	if any, leading to immediate Cause Enter Underlying Cause (Disease or iinjury that initiated events									- 1	
	exec ian an irial-tr	E	resulting in death) Last	Due to (or as a consequ	ence of):							
00	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical		d									
200	ertific ding p se as	Ž	IF FEMALE:	23c. If yes, out	come of pregnar	ncv							
Box 68	atten atten I for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live I	Birth 2 Fetal	Ideath 3	Ectopic preg Other (specif				2	3d. Date of deliv! Month	ery Day Year
	the de by the ached	hys	9 Unknown	g 🗌 Unkn	own								
л Э	s that gned to	by F	Part II. Other significant condit					_	rt I.				ne cause of death?
ĠS,	equires een się ould b	ted	chronic bactere	mopathy,	penphua	u vasa	ular de	susc		1 🗆 ነ	Yes 2	KNo 3 ☐ Pro	bably 4 Unknown
<u>S</u>	law re has be e 2 sh	Completed by	chronic bactere	mra, coron	ary an	tery de	sease			24a. Was a autop	sv	prior to co	psy findings available mpletion of cause of
Ĕ	: The icate r, pag									1 🗌 Yes	2 No	death?	2XNo
Vital Records,	siciar certif lirecto	00	25. Was case referred to medical examiner?1 ☐ Yes 2 ☐ No	Hospital	·	ED/0	T	Other:		, ,			
	g Phy er this reral d	Fe: To	27. Manner of Death	28a. Date	Inpatient 2 1	28b. Time of	28c. I	njury at		me 5 ∐ Resid 28d. Describe h		Other (Specify occurred)
o	endin sath. or: Aft he fur	fical		tigation	h, Day, Year)	injury		vork?	□No				
DIVISION OF	or Att	Certificate;		minod 28e. Place	of Injury - At hor ng, etc. (Specify)		et, factory, off	ce		28f. Location (S City or Town		Number or Rural	Route Number,
5	pital ours a eral C		29a. Certifier 1 Certifyir	g Physician: To the be	act of my knowle	odgo doeth o	poured at the	ima data au	d = a = = = =		(-)		_
	e Hos n 24 h e Fun eleted	Medical	(Check 2 ☐ Medical	Examiner: On the basing Nurse Practioner: 1	s of examination	and/or investi	gation, in my o	pinion, death	occurred at	the time date at	nd place :	and due to the car	use(s) and manner stated.
	To th To th COME		29b. Signature and title of certific					ense number				signed (Month,	
)		ALW	Physician			PZ	444	4			6/4/2	010
			30. Name and address of persor	who completed cause	e of death (Item	23a) (Type, P	rint)	2 1.					
	Stat		Alice Wong 31. Date filed (Month, Day, Year)	ZZ South 7 2010 32. Re	Green	re Str	cet i	salhm	me, M	D 212	201		
	Registra	-	JUN (7 2010	insur	13. 14	parke						

DHMH 17 Rev 7/2009

10

)-04138		Please Type or Print in Black Indelible			egible.	
ichael Aaron H	latc	otate of maryland, population		ygiene	()	· ·
		1- For State Certificate Registrar	of Death		Reg. No.	0 /03
Physici ledical Exami		1. Decedent's Name (First, Middle,Last)		2, Date of De Month May 30, 2	Day Year	3. Time of Death 1124 hrs
iodiodi Exam		Michael Aaron Hatch, Sr. 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	
		University Hospital	Baltimore		N/	A
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	_		Birthplace (State or Foreign Country)
Director		$213-92-2083 \mid _{1 \boxtimes M} \mid _{2 \square F} \mid 32$	rs. Months Days Hours Min	Jan.1	9,1978 M	
λ.		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	otion			10d. Inside City Limits
ow any		Maryland Anne Arundel Annapol				1 Yes 2 No
ryland a-f sh f once	ctor	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	
th the Maryland 23a or 28a-f show notified at once.	Director	703 Great Bay Ave	21401	-	-	,
with tl is 23a e noti			Vas Decedent of Hispanic Origin? (Sp	pecify Yes or N	USA o- 14. Race - Ar	nerican Indian, Black,
leath r	uneral		Yes, specify Cuban, Mexican, Puerto		White, etc	.
after call, o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 No specify:		Specify:B1	ack
hours	eted k	durino	ent's Usual Occupation (Give kind of v most of working life, DO NOT use reti		16b. Kind of Busine	ss/Industry
36 in 72 han " lical J	plet	Elementary/Secondary (0-12) College (1-4 or 5+)		,	Private	Industry
d with	Comple	11 th grade Labo:		(First, Middle,	Maiden Sumame)	
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiewei. 2 si is marked other than "natural", or items 23a or 28a-fish 27 is marked other than "natural", or items 23a or 28a-fish 2matic event, the Medical Examiner must be notified at once		Worlow Hatch	G1 7.7		•	
21; ould b d Men s mar	Tol	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ng Address (Street and Number or F	Rural Route Nu	imber, City or Town, Si	ate, Zip Code) 21401
nore, MD 2121 ges 1 and 2 should be fi nt of Health and Mental t: If item 27 is marked other traumatic event,		Shelly Gross/Mother 703	Great Bay Avenı	ıe Ann	apolis.Ma	arvland
ore tra		20a. Method of Disposition 20b. Place of Disposition Removal from State 20b. Place of Disposition State	osition (Name of cemetery, other place) 6 / 5	Date 7 / 1 0	20c. Location - City	
Page Page ment c		4 Donation 5 Other Specify: Greenmon	int Cemetery	, ,	Baltimore	e,Maryland
Baltimore, MD 21215-003 permit Pages I and 2 should be filed with popartment of Health and should the stygene Department If firem 27 is marked other I migury or other traumatic event, the Mag			Name and Address of Facility Cha	atman-	Harris F	uneralHome
		23d. Part I. Enter the disease, or complications that caused the death. Do not enter	<u>240 Reisterstow</u>	vn Rd	Baltimore	Approximate Interval
Physician /Medical		failure. List only one cause on each line.	the most of dying, soon as earlies o	respiratory an	rost, shook, or heart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound to the Back Due to (or as a consequence of):				
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
· C · ·	kam	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
and and transit	alE	d				
ਜ਼ ਜ਼ੋ ਫ਼	dic	UNPENDED AMENDED				
Box 68760, e death certificate butten attending physic ed for use as the but	sician/Medic	IF FEMALE: 23b. Was decedent pregnant in the			23d. Date of deliv	•
OX 687 eath certific	ciar	past 12 months?	Fetal death 3Ectopic pregna Dther (Specify)	incy	Month	Day Year
Boy death	Physi	1 Yes 2 No 9 Unknown 9 Unknown	Julie (Speedy)			
C # P P	by Pł	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.			to the cause of death?
S, P.C						robably 4 Unknown
cords, law requir has been s 2 should l	plet			24a. Was auto	psy prior	autopsy findings available to completion of cause of
Rec The la cate h	Completed			1 ✓ Yes	ormed? death 2 No 1	
Division of Vital Records, rate or Attending Physician: The law require at or Attending Physician: The law require at Jurice or After this certificate has been sited in by the funeral director, page 2 should be	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check of			
F Vic	Tol	1 ✓ Yes 2 No Inpatient 2 ✓ ER/Outpatie		g Home 5	Residence 6 Ot	her:
ding ding Afte	e ::	27. Manner of Death 28a. Date of Injury 28b. Time of May 30, 2010 1 Natural 5 Pending May 30, 2010		Subject wa	how injury occurred s shot	
SiO Atten r death ector; by the	Certification:	2 Accident Investigation		28f Location	(Street and Number or	Rural Route Number, City
Divi	į	Suicide Could not be determined (Specify) 1 = ==1 Otan = 1	eet, factory, office building, etc.	or Town,		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	ပိ	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ	urred at the time, date and place, and			
To the Hos within 24 h To the Fur completely	edical	one) 2 Medical Examiner: On the basis of examination and/or investig	ation, in my opinion, death occurred a	t the time, date	and place, and due to	the cause(s)
F 2 2 2	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (/	Month, Day, Year)
		County buthall, MA	O.C.M.E.		May 31, 2010	
3		30. Name and address of person who completed cause of death (Item 23a)			1	
		Pamela E. Southall, MD Assistant Medical Examiner 1	11 Penn Street, Baltimore, M	1D 21201		
Si Regis		31. Date filed (Month, Day, Year) 32. Registrar & Signature 33. Registrar & Signature 33.				

State 31. Date filed (Month, Day, Year)
Registrar JUN 0 7 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Gordon Heffley Danie1 2010 8:43a Medical June 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carrol1 Carroll Hospital Center Westminster Social Security Number 8. Date of Birth (Month, Day, Year) Feb 2 1926 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 OTT 7. Age (In yrs. last birthday) **Funeral** Min. 1 🕅 M 2 🗆 F Hours 297-18-4529 84 OH Director Yrs Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f s notified MD Eldersburg Carroll 1 🗆 Yes 2 🔀 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r Funeral 2013 Rudy Serra Drive -21784 USA Unit 1D 12. Was Decedent Ever in U.S. "natural", or item edical Examiner n 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married WWII 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 Divorced Specify: white the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I B & O Railroad operations manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Helen V. Wyant Daniel A. Heffley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2013 Rudy Serra Dr., Unit 1D, Eldersburg, MD 21784 Virginia Heffley (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State All County Cremation Sykesville, MD 6-9-10 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Paige Haight I P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Purnoni if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Yes 2 No 1 Yes 2 9 Unknown been signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has autopsy 2 1 ☐ Yes 2 ☐ No Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 욘 1 Yes 1 npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accider
Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0057619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOSHUGL MF RUDENFELD 838 31. Date filed (Month, Day, Year) 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar			rtificate o	f Death		Reg. N	2010	1/593
	Physicia	an/	Decedent's Name (First, Middle, La Dewey	,				2. Date of De		ay Year	3. Time of Death
-bay	Medi Examir	cal	4a. Facility Name (if not institution, give	Glenn Hopkin	ıs	4b City Town	, or Location of Deat	June h	\neg	2010 c. County of Death	6:00am M
4	LAdiiii	161	Carroll Hospice			4b. Oity, lowii	Westmins		40		roll
	Funeral Director			Sex 7. Age (In yrs. & 74	ast birthday) Yrs.	If Under 1 Year Months Day			rth 12 ^{Year)}	9. Birt	nplace (State or Foreign Intry) MD
	and show	ě	10a. State 10b. County	10c. City	y, Town or Lo	cation					10d. Inside City Limits
	Maryl. 28a-f otifiec	irect	MD Carr	o11		Syke	esville				1 🗆 Yes 2 🎇 No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral Director	10e. Street and Number 7414 Second Ave	nue		10f. Zip Code	• :1784		10g. C	itizen of What Co	untry? SA
10	r deat or iten niner r	y Fu	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13. V	Was Decedent of f Yes, specify Cu	f Hispanic Origin? (S uban, Mexican, Puert	pecify Yes or No- o Rican, etc.)		14. Race - Amer Black, White	
036	ırs afte ıral", o I Exan	ed b	1 ☐ Never Married 2 😾 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 1958-	-60	I ☐ Yes 2 🔀 I	No Specify:			Specify: Wh	ite
15-0	72 hou I "natu edica	plet	15. Decedent's (Specify only highest g	Education	16a. Deced		e during most of wo	rking	16b.	Kind of Business I	ndustry
12	vithin 7 iene. r than the M	S	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. D	o NOT use retire Carpe	•	-	1 ,	Construc	tion
β	filed wall Hyg I othe	Be	17. Father's Name (First, Middle, Last)			332 P 3	18. Mother's Na	ne (First, Middle			
ylaı	Menta Merita narked	₽	Henley Hopk	ins			Mu	sa Davis	3		
Baltimore, Maryland 21215-0036	nd 2 shou ealth and m 27 is m		19a. Informant's Name/Relationship (Mrs. Shirley Hop	** * *	1	-	et and Number or Ru Avenue, S				Code)
Jore	ge 1 a nt of H :: If ite or oth		20a. Method of Disposition 11 Burial 2 Cremation 3	Removal from State	emetery, cren	sition (Name of natory or other p		Date	i	ocation - City or	
Ħ	nit. Pa artmei ortant injury		4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Licer				ardens 6/				
B	permi Depar Impor any ir		Dauge Haugh			PO Box	195 Sykes	ville, N	MEKA MD 2	L номе & 1784	CHAPEL, P.A
I	Physician/ Medical		23a. Part 1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line. Severe	COPD						Approximate Interval Between Onset and Death 15 years
1	Examiner		resulting in death)	Due to (or as a consequ		Artory	Disease)				10 months
		iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Dian to for an a nunanqui		Artery	Disease)				10 months
	cuted	Examiner	Cause (Disease or iinjury that initiated events	c. Congesti		rt Fail	ure				3 months
00	cate be executed physician and the burial-transit	Medical E	resulting in death) Last	Due to (or as a consequent of the date of		ation					7 months
68760	rtificat ling ph e as th		IF FEMALE:	00.15							
Box (Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnar 1 Live Birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	Ectopic pregna Other <i>(specify)</i>	ancy			23d. Date of deli Month	very Day Year
s, P.O.	es that the signed by		Part II. Other significant conditions of Type II Diab		ulting in the u	nderlying cause	given in Part I.				the cause of death?
of Vital Records,	require been si should	Completed by	Asthma					24a. Was			opsy findings available
3ec	The law rate has page 2	duo							ormed?	prior to co death?	ompletion of cause of
<u>la</u>	i cian: The certificate ector, paç	BeC	25. Was case referred to medical examiner?			26.	Place of Death (Che		2 X N	o i res	2 L NO
f Vii	Physicia this cert	은	1 Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 I		t 3 🗆 DOA				3 🗓 Other (Specif	wHospice
0	ng Tel	Certificate:	1 Mariner of Death 1 Mariner of Death 1 Mariner of Death 1 Section 1 Sec	(Month, Day, Year)	28b. Time of injury		ury at ork? □ Yes 2 □ No	28d. Describe I	how injur	y occurred	
Division	Hospital or Attending 24 hours after death. Funeral Director: After sted filled in by the fune		4 Homicide determined		ne, farm, stre	et, factory, office	e	28f. Location (S City or Tov		nd Number or Rura !)	al Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical	(Check 2 Medical Exam	rsician: To the best of my knowled liner: On the basis of examination The Cliner: To the best of my	and/or investi	igation, in my opi	nion, death occurred :	at the time, date a	and place	e, and due to the ca	ause(s) and manner stated.
	To 1 To 1		29b. Signature and title of certifier	dun		29c. Licer H463	nse number 26			te signed <i>(Month,</i>	Day, Year)
	(o V		30. Name and address of person who Randi Braman, M.			,	dereburg	MD 2179	 R4		
	Stat	e					derendig,	LID 71/0	J ≒		
	Registra	ır	31. Date filed (Mosth, Day, Year)	32. Registrar's Signat	arked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** GERROD AM KEVIN JUNIOR UITLE 04 0 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HEDICAL CENTER BALTIMORE BALTIMORE UTY. Birthplace (State or Foreign Country) Social Security Number If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) If Under 1 Year **Funeral** 8. Date of Birth (Month, Day, Year) Days Min. 1 **⊠** M 2 □ F Yrs. Director 51 10 2010 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits 10c. City, Town or Location 28a-f show Examiner must be notified at 1 XYes 2 ☐ No Funeral Director MD Itimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō items 23a 2119 USA 21217 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Completed by Specify: 3 Widowed 4 Divorced Black 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than 'am injury or other traumatic event, the Meonee. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Quanetta Kevin errod 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ranch Vuanetta Melson ave MO Himore 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Catherray 4 ☐ Donation 5 ☐ Other (Specify) 7-30-10 Balto. mi 22. Name and Address of Facility Prad/ay-Ashton Funckal 21. Signature of Funeral Service Licensee 2134 W, 1/00 Road alasa Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** EXTREME PROMATURITY /Medical Due to (or as a consequence of): Examiner PRETERM. MOMBRANES HOURS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): burial-1 Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) signed by the a 9 Unknown NIA NID NIA Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ficate has been siç r, page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 X No 1 □Yes 2 ☑No 1 Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Tes Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at ₩ / A 28d. Describe how injury occurred 1 Natural 5 Pending Injury within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation NIA MI 2 Accident MIA 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide N 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who co

29b. Signature and title of certifier

PAUL ST

32. Registrar's Signature

21202

AU4176435H78277

29c. License number

29d. Date signed (Month, Day, Year)

ed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month 05 Physician/ INIEL ENKINS 10:30 0 Medical 4a. Facility Name (if not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** OF MD CENTER MEDICAL BACTIMORE Social Security Numbe 7. Age (In yrs. last birthday) If Unde If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 □ F Months Days (Month, Day, Hours Min. 80 Director **213-24-7689** 1930 Maryland Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No PA Adams Gettysburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 429 Barlow Two Taverns Rd 17325 U.S.A permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Evaminar musus injury or other traumatic event, the Medical Evaminar musus injury or other traumatic event, the Medical Evaminar musus injury or other traumatic event. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. by 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. Specify. Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 carpenter construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Schley Jenkins Muriel Marie Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara R. Deeds/daughter 318 Stultz Rd. Fairfield, PA 17320 20a. Method of Disposition 20h Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Sam's Creek Cemetery ! 5/31/2010 New Windsor, MD 22. Name and Address of Facility Hartzler Funeral Home of Foreral Service Lice a 23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

31. Date filed (Month, Day, Year)

\mathcal{L}	. Hay Leer	310 Church St	., New Windsor	MD 21776
one	cations that caused the death. Do not cause on each line.			Approximate Interval Between
_ a	INTRACEANTAL	. HEMORRHAGE	E 1	Onset and Death
	Due to (or as a consequence of):			
b	MOTUR VEHICL	E COUTINO	N pera	12 DAYS
	Due to (or as a consequence of):	$-\Delta$	CATTON APPROVED BY MEDICAL EXAMINER	135
С	Due to (or as a consequence of):		SPROVED BY WEDIL	
	5 45 15 (4. 45 4 55 115 440 115 5 5 1)	CERTIFIC	CATTON APT	
= d				

069632

GREENE ST BALTETRORE MO

Month

death? 1 Yes 2 No

Day

3 ☐ Probably 4 ☐ Unknown

Were autopsy findings available prior to completion of cause of

2010

21201

Exami Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PUL MONARY CONTUSTIONS 2 No 1 Yes 24a. Was an autopsy ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) xammer? 1 Yes 2 🗌 No Other: ျပ 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending injury MOTOR VEHICLE COLLISION 1026 AM 1 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ROUTE 15 NORTH BOUND 4 Homicide determined STREET REDDY CREEK RD THURMONT MO 21788 Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the bests of examing for and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check Certifying Nurse Practioner: ϕ f my kinowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

24 hours

within 24 hor To the Fune completed fi

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

attending physician a for use as the burial-

signed by the a

certificate has been si rector, page 2 should

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Loraine Johns 2010 5:00 Helen June A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Transitions Health Care Sykesville Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F Director 215-24-7332 1929 May 6. Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Carroll New Windsor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15057 New Windsor Road 21776 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐Yoo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: þ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Heath and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, that Ma once. Elementary/Secondary (0-12) College (1-4or 5+) 10 own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William E. Jones Helen Kyte ၉ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roy W. Johns Sr./ husband 15057 New Windsor Rd. New Windsor, MD21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) MD Veterans Cemetery: 6/10/2010 | Garrison Forest, MD 22. Name and Address of Facility
Hartzler Funeral Home 21. Signal r of 50 eral Service Licer Jarine all 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that dured the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final MI Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Month 5 Other (specify) P.O. detached 9 Unknown cate has been signed, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 Ne 1 ☐ Yes 2 🖼 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Universing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death.

To the Funeral Director; / 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) -0054218 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Malcaly dury Wertmine MD 32. Registar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Elon Jerome Jones	1- For State Certificate of Death	nd Mental Hygiene 2010 17599
Physician/ Medical Examiner	Decedent's Name (First, Middle,Last) Elon	2. Date of Death Month Day Year May 30, 2010 3. Time of Death 0915 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, of Hyattsville	r Location of Death 4c. County of Death Prince George's
Funeral Director	5. Social Security Number 054-76-4525 6. Sex 17. Age (In yrs. last birthday) 21 Yrs. Months Day	12 02 1000 1
ny	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
land f show as once.	MD PG Hyattsville	
h the Maryland 3a or 28a-f sh otified at onco	10e. Street and Number 10f. Zip Code 207	782 USA
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itani: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director		spanic Origin? (Specify Yes or No- n, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack, White, etc. Specify: Black
ours aft atural" xamine	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupa during most of working life	ation (Give kind of work done 16b. Kind of Business/Industry
5-0036 led within 72 hour lygiene 'hour than "natu the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Laborer	Private
ore, MD 21215-003 se I and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other th ther traumatic event, the Med To Be Comy	17. Father's Name (First, Middle, Last) Reginald Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street)	18.Mother's Name (First, Middle, Maiden Surname) Karen Gumbs
MD 21 d 2 should d 2 should th and Me n 27 is ma umatic ev	Karen Jones/Mother 6000 42nd Ave	et and Number or Rural Route Number, City or Town, State, Zip Code) 2. #102 Hyattsville, MD 20781
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica To Be Complé	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of ce crematory or other place) Riverdale Pk Crem	06-03-2010 Riverdale, MD
Baltimo permit. Page Department o Important: injury or ott	handal Mel (ne O) 10583 Midd	s of Facility Onald Taylor II FH Heport Ln. White Plains, MD 20695
Physician / /Medical	Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, failure. List only one cause on each line. Immediate Cause (Final disease a. Carbon Monoxide Toxicity	such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a consequence of):	
niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or Injury that imitiated	
b, ce executed cician and arial - transit	events resulting in death) Last Due to (or as a consequence of): d.	
	UNPENDED AMENDED	
lox 68 leath certi eattendin for use as	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	Ectopic pregnancy
P.O. E res that the d signed by the be detached d by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. as for death. The law requires that its after death. The law requires that it along the serificate has been signed by led in by the funeral director, page 2 should be deadler in the funeral or the serification: To Be Completed by P.		24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No
Vital Recysician: The his certificate director, page	examiner?	o of Death (Check only one)
n of Vi ding Physi n. After this funeral dir on: To	27. Manner of Death 28a, Date of Injury 28b, Time of Injury 28c, Injury	Other4 Nursing Home 5 Residence 6 ✓ Other Scene ry at Work? 28d. Describe how injury occurred
Sion (Attendin death. ector: Ay the fur	2 Accident Investigation May 30, 2010 0904 hrs	exposure to combustion engine fumes
Division of the Hospital or Attending hin 24 hours after death the Funeral Director. After pletely filled in by the fine dical Certification:	3 Suicide 6 Could not be determined (Specify) Townhouse / Rowhouse	or Town, State) 5611 38th Avenue, Hyattsville, MD
To the Hos within 24 h To the Fur completely	Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	
Me T × N	29b. Signature and little of certifier O.C.I. O.C.I.	, , , , , , , , , , , , , , , , , , , ,
\	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, B	Saltimore, MD 21201
State Registrar	31. Date filed (Month, Day Year) 32. Registrar Signature	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Euphemia 20 A M N. Johnson 10 6 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner FRANKLIN SQUARE HOSPITAL 9. Birthplace (State or Foreign Rosedal 8. Date of Birth (Month, Day June 25 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs **Funeral** 1 □ M 2 🗙 F Months Days Hours Min. 1926 Mary Tand 83 218-22-6077 Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Experiment must be notified at Baltimore Parkville Director Maryland 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8800 Walther Blvd. Apt. 3217 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: ₽ S Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Expense Accountant Accounting permit. Pages 1 and 2 should be filed wit. Department of Health and Mental Hygien Important; If item 27 is marked other tha any injury or other traumatic event, that once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williamson William Nethken Joan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8800 Walther Blvd. Apt. 3419 Parkville, MD. Carrie Hemberger / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Druid Ridge Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/7/2010 Pikesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 1 Funeral Service Licer 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** DYSFUNCTION mulli organ disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Severe SIS Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner he to (or as a consequence of). burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 □Yes 2 □ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

P.O. Box 68760, Division of Vital Records, To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After

with the Maryland

death

filed within 72 hours after

21215-0036

Maryland

2

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title

DRSTEPHEN

Selinger 40 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R

4000

29d. Date signed (Month, Day, Year) 6-3-2010

FRANKLIN SQUARE DR Balto md 21237

AMEND ITEM#2 per PHYS G904 6/7/2010 WS Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death June 01, 2010 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, 1 M 2 F Director 216-20-3748 83 Usual Residence of Decedent fshow 10a. State 10b. County filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 MT. WILSON LANE, #623 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: WHITE 3 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ pe 1 MARTIN B KOHN ROSA ROSENTHAL plnous 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau EAST LEE STREET, #2105, BALTIMORE, MD ELIZABETH MOSER/SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM: 6/4/2010 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 21. Signature of Funeral Service License SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to or as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consection over? the attending physician and thed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the s should be detached 1 ☐ Yes ∠ ≠ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2 a autopsy performe Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 흔 1 🗌 Yes 2**X** No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 V ron 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	ase Type or P					-		_egible.				
	•	For State Registrar	State of I	Marylan		rtment of F tificate of L	lealth and N Death	nental Hy	giene Reg. No.	010	17602			
Physicia	n/	Decedent's Name (First, Middle		77				2. Date of De Month	Day	Year	3. Time of Death			
Medic	al	Laurence 4a. Facility Name (if not institution		Krause	5	4b City Town or	Location of Death	June	2	2010 ounty of Death	1:45 A ^M			
Examin	er	Gilchrist Hosp		,		Towson	200411011 31 204111			ltimor				
Funeral		5. Social Security Number		Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	rth av. Year)		nplace (State or Foreign intry)			
Director		212-44-2690 Usual Residence of Decedent	T LES WIZ CIT	_65	Yrs.			02/26	71945	Ic	owa			
and show dat	tor	10a. State 10b. County		10c. City	y, Town or Loc	ation					10d. Inside City Limits			
Mary 28a-f otifie	Director	MD Balt	imore	To	wson						1 X Yes 2 □ No			
th the 3a or t be n	ralD	10e. Street and Number	-7			10f. Zip Code			•	en of What Cou	untry?			
ath wi	Funeral	1106 Gypsy Lar	12. Was Deceder	nt Ever in U.S	S. 13. W	21286 /as Decedent of Hi	ispanic Origin? (Spe	ecify Yes or No-	U.S	. Race - Amer	ican Indian.			
ter de , or its	þ	1 Never Married 2 🔀 Mar				Yes, specify Cuba ☐ Yes 2 🔀 No	n, Mexican, Puerto	Rican, etc.)		Black, White	, etc.			
rurs af tural" al Exa	ted	3 Widowed 4 Divorced	1 real of Dates								White			
72 hc In "na Medic	Completed	(Specify only high	ent's Education est grade completed)		(Give k	ent's Usual Occup: ind of work done o NOT use retired)	ation luring most of work	ing	16b. Kind	of Business I	ndustry			
within giene. er tha		Elementary/Seconday (0-12)	College (1-4 o	or 5+)	P	ublisher			F	rintin	q			
e filed ntal Hy ed oth eveni	To Be	17. Father's Name (First, Middle,	*				18. Mother's Nam	e (First, Middle,						
ould b		Norman Ca		ause	10h Mailin	a Address (Street	Clara and Number or Rura	al Poute Numbe		eisman State Zin	Code)			
12 shealth an 27 is r trau		Alice Cherbon			1		ane West,				2000)			
of Head of Head If item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	2 Pamoval from Sta		Place of Dispos	sition (Name of atory or other place	e)	Date	20c. Loca	ation - City or T	Town, State			
Page tment tant: jury o		4 ☑ Donation 5 ☐ Other (Specify)		itany Gif	ts Registr	y 06/0	3/2010	1		aryland			
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signatore of uneral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076												
		23a. Part 1. Enter the disease, or	r complications that cau	the death					-		Approximate			
Physician/		shock, or heart failure. List Immediate Cause (Final disease or condition	21	ddw	C	nncer					Interval Between Onset and Death			
Medical Examiner		resulting in death)	Due to (or a	as a consequ	uence of):									
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or a	as a consequ	uence of):									
uted	xaminer	Cause (Disease or linjury that initiated events	c											
ath certificate be executed attending physician and for use as the burial-transit	ш	resulting in death) Last	Due to (or a	as a consequ	uence of):									
cate b physic the b	edic		d											
certifi ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			Ectopic pregnance	:V		23	d. Date of deli	very			
death the att	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnan 9 Unknow	it at time of c		Other (specify)				Month	Day Year			
hat the ed by detacl		Part II. Other significant conditi	ons contributing to death	h but not res	ulting in the ur	nderlying cause giv	ven in Part I.	23e. Did	tobacco use	contribute to	the cause of death?			
uires t en sign uld be	ed b							10	Yes 2	No 3 Pr	obably 4 🗌 Unknown			
aw red as bee 2 sho	Completed by							24a. Was	psy	prior to c	opsy findings available completion of cause of			
: The l								1 🗌 Yes	ormed? 2 No	death?	2 🗆 No			
sician s certif	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ationt 2 🗆	ER/Outpatien	Oth	er: 4 Nursing H		idence 65	Other (Speci	whospile			
ng Phy ter this neral o		27. Manner of Death	28a. Date of i		28b. Time of injury	28c. Injury	y at	28d. Describe						
ttendii death. tor: Ai the fu	Certificate:	2 Accident Investi	igation	Inium. At ho	mo form otro	M 1 🗆	Yes 2 ☐ No	29f Location	(Ctroat and I	Number or Pur	al Route Number,			
al or A		4 Homicide determ		etc. (Specify)		ļ	City or To	wn, State)					
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical I	g Physician: To the best Examiner: On the basis of g Nurse Practioner: To t	of my knowl	ledge, death on and/or investi	ccured at the time igation, in my opinion	, date and place, ar on, death occurred a e time, date and pla	nd due to the ca	ause(s) and and place, a he cause(s) a	manner as stated	ted. cause(s) and manner stated stated.			
To the Within To the comp	2	29b. Signature and title of certifie				29c. License	, date and place, ar on, death occurred a e time, date and place e number \$^8 3 0 3	>	29d. Date	signed (Month	JOIO			
61		30. Name and addless of person	who completed cause of	of death (Item	1 23a) (Type, Pr	rint) N. C	haries	SFT	105 Mg	v M)			
Staf		31. Date filed (Month, Day, Year)	32. Regis	strar's Signal	ture				-					
Registra	ar	JUN 0 "	7 2010	wa	13. A	arke								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O4 Year **Physician** Day Gregoary L 00:15 AM Onnell 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Mercy Medical Center

5. Social Security Number 6. Sex 7. Age (In) Baltimore Baltimore City 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 15 M 2 □ F Months Days Hours Min. Director NIA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner is ust be notified at Director 1. Yes 2 No MO Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 212 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ► No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) Be Ge Uvonne 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Quanetta /le/son timore 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 30-10 4 ☐ Donation 5 ☐ Other (Specify) Ba 21. Signature of Funeral Service Licensee Bradley-Askton Home, PA, 2134 WI 110W SARING 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Extreme prematurit /Medical Due to (or as a consequence of): 62 hrs Examiner reterm premature rupture of membranes Equalities, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed burial-trar and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Po Day Year 5 Other (specify) P.0. signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy Hospital or Attending Physician: The certificate performed 2 1 No Division of Vital 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **1** No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 24 hours after deat Funeral Director: 3 Suicide Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kitessa 301 PhuBaltimore, MD Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ May 30. 2010 11:52 Рм David R. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Berlin Worcester Atlantic General Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 220-48-7455 1 **X**M 2 □ F Months Days Hours Min Mary land Yrs 1950 Director 60 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Phoenix Md Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 5 Cross Creek Court 21131 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify: 3 Divorced 4 Divorced Completed White permit, Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Baltimore City Public life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Athletic Director School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Conrad С. Lang Eileen Schmaelzle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Μ. Sharon Lang/Wife Cross Creek Ct. Phoenix, Maryland 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 $\overline{\mathbf{X}}$ Burial 2 \square Cremation 3 \square Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. 6/5/10 Timonium, Maryland 21. Signature of Funeral Septice Licenses 22. Name and Address of Facility RUCK TOWSON FUNERAL HOME, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NIYOCARDIAL disease or condition MINS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Examin and -tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Vital To Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 IDOA nours after death.

neral Director: After this
d filled in by the funeral di Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural 5 Pending Investigation 6 Could not be Accident ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WORTH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

2410

30

6

David

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Lavin James June 2010 1:00A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1015 Norman Drive, Apt 103 <u>Annapolis</u> Anne Arundel Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1 🛣 M 2 🗆 F Months Davs Hours Director 563-36-0377 80 05/29/1930 California Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County show 10d. Inside City Limits r 28a-f sh notified 1 XIYes 2 □ No Director MD Anne Arundel Annapolis 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? "natural", or items 23a or edical Examiner must be r 1015 Norman Drive, Apt. 103 21403 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify 2 Specify: 3 X Widowed 4 ☐ Divorced White Completed arment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natur injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Systems Engineer Air Traffic Control 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Miles ပ Francis Lavin Viola G. Cordes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph P. Lavin / Son 1015 Norman Drive, Apt. 103, Annapolis, MD 21403 Department of Heal Important: If Item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 06/03/2010 Hanover, Maryland Anatomy Gifts Registry 22. Name and Address of Facility Anatomy Gifts Registry 21. Signatore of Furteral Seprice Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performed funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural 2 Accident 5 Pending investigation Injury • Hospital or Att.

• ours after death.

• Director: A^P 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 🗷 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the l within 2. To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DS2830 JUNE 2, 2010 nine weine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1900 Bestgate Road #300 Annapolis, up 2010

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

10-04208 Burton Lock, Jr.		Please Type o State	r Print in Bia of Maryland /								10	17606
		1- For State Registrar		-	tificate o				R	eg. No.		1000
Physicia Medical Exami		Decedent's Name (First, Middle, Last							Date of Dea Month May 2, 20	th 6/ _y 2/20 ₁ 1	p	3. Time of Death 2035 hrs
gram.		4a. Facility Name (if not institution, give 523A Stevenson Lane	street and number)			4b. City, Town, Towson	or Location o	of Death		4c. County Baltimo		
Funeral		5. Social Security Number 6. Se		(In yrs. la	st birthday)	If Under 1 Y			8. Date of 8in	th(MM/DD/YYY	Y) 9. 8ir Foreiç	thplace (State or
Director		218–62–5126 ₁XX	м ₂ _ _F 58		Yrs		ays Hours	Min.	02/29/19	952	Co	untry Mary land
any		Usual Residence of Decedent 10a. State 10b. County	[1	Oc. City,	Town or Locat	ion						10d Inside City Limits
	>	Maryland Baltimore		Towsor	1							1 Yes 2 XX No
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at once.	Director	10e. Street and Number 532A Stevenson Lane	•			10f. Zip Code 2128			1	0g. Citizen of W USA	hat Cou	ntry?
with the		11. Marital Status	12. Was Decedent E	ver in U.S							ican Indian, 8lack,	
death or item	Funeral	1 XXNever Married 2 Married		No	If Y	es, specify Cub		Puerto Rio	can, etc.)	Whit	e, etc.	*1
urs after tural",	>	3 Widowed 4 Divorced 15. Decedent's Education (Specify on	If Yes, Give Year or Dates: y highest grade comp	leted)	1	Yes 2 XX 1		rind of wor	k done	Specify: 16b. Kind of 8t		ite
72 hour	eted	Elementary/Secondary (0-12)	College (1-4 or 5+			ost of working l						industry
0036 within iene.	Completed		2		Can	penter	1.0.0.0			Disable		
21215-0036 buld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be C	17. Father's Name (First, Middle, Last) Burton Vermon Lock						,		Maiden Surname B Goldbeck		
2 a g a s	70	19a. Informant's Name/Relationship (Ty					eet and Numi	ber or Rura	al Route Num	ber, City or Tow	n, State	
, MD and 2 sho ealth and em 27 is		Louise A Lock 20a. Method of Disposition	Sister			PedDIE CI			CNETVIII	e, Maryla		
Baltimore, permit. Pages la Department of He Important: If ite		1 XX 8urial 2 Cremation 3	Removal from State	e cr	rematory or ot			06/07/	/2010	Baltimor		
altin mit. P. partme portan ury or		Donation 5 Other Specify: Signature of Funeral Service License	ee //	/ ·						eld Funera		
		Neurus Stake	nyquan	W.		6500 You	rk Road	Baltin	nore, Ma	ryland 21	212	
Physician /Medical		23a. Part I. Enter the disease or complifailure. List only one cause on each					g, such as ca	rulac or re	sspiratory arre	est, shock, of he	arı	Approximate Interval 8etween Onset and Death
Examiner	İ		ue to (or as a conseq			ease						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ue to (or as a conseq	uence of)	:				<u></u>	<u> </u>		
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	ue to (or as a conseq	uence of):								
execul an and al - tra	ical	UNPENDED d.	AMENDED									
68760, certificate be nding physici	ician/Med	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregna	· —	tal death 3	Ectopic	pregnancy	,	23d. Date of Month		year Year
Box 61 e death cert the attendir	' io	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at tir	me of deat	·	ner (Specify)		,				
O. B. t the de by the	된		9 Unknown contributing to death b	out not res	sulting in the u	nderlying cause	given in Par	t I.	23e. Did to	bacco use contr	ibute to	the cause of death?
F, P.O.	d by		·						1 Yes	2 No 3	Prob	ably 4 🗸 Unknown
ords aw requas beer	ompleted								24a. Was a autops	sy p		topsy findings available ompletion of cause of
Rec The l	O					00.81	- 10 - H 11	2111	1 ✓ Yes 2		√ Ye	s 2 No
/ital	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No	espital: 1 Inpatient	2 E	R/Outpatient		Other	Nursing H		Residence 6	✓ Other	: Scene
Division of Vital Records, P.O. Isl or Attending Physician: The law requires that the rather death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	⊢⊦	27. Manner of Death	28a. Date of Injury (Month, Day,Year	r) 2	28b. Time of Ir		jury at Work?		d. Describe h	ow injury occurr	ed	
Sior Attend r death. ector: by the 1	catic	2 Accident Investigation	29a Bloca of Injur	nr - At hon	no form stree	_	Yes 2 1		f Location /S	treet and Number	ar or Pu	al Route Number, City
Divi	ertification:	3 Suicide 6 Could not be determined	(Specify)	y - At 11011	ne, raim, siree	it, lactory, office	Dulluli ig, etc.	. 201	or Town, St		si oi Kui	al Route Number, Oity
	Medical C	29a. Certifier 1 Certifying Physicia (Check only one) 2	n: To the best of my k	nowledge	e, death occuri d/or investigati	red at the time, on, in my opinio	date and place on, death occi	ce, and due urred at the	e to the cause e time, date a	e(s) and manner and place, and d	as state ue to the	ed. e cause(s)
To with Con	Ě	29b. Signature and title of certifier	and manner stated.				se number			29d. Date signe		
			ellain			0.0	.М.Е.			June 3, 201	10	
		30. Name and address of person who co Carol Allan, MD Assistan	mpleted cause of dea t Medical Examil			Street, Baltin	nore, MD	21201				
Sta Registi	100	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		barker						
			-		1 60							

DHMH 17 Rev 1/2001 OCME 2006

OCME

	Pleas	se Type or P						All Copie Mental Hy		_	le.	
For State Registrar			naryiai		tificate			- Iviental my	Reg. N	2011)	17607
1. Decedent's Name		•						2. Date of D _Month	Г	ay Yea	ar	3. Time of Death
Mohamme 4a. Facility Name (if		 Mohagive street and number; 	mme	<u>f</u>	4b. City, Tov	vn. or Loca	tion of Deat	6-3-2	<u> 2010</u>	c. County of D		3:46a [™]
holy C	ross H	ospital				ver	Sprin	ngs		Montg	ome	
5. Social Security Nu 115-68-2	2961	6. Sex 1 X M 2 \square F	ge (In yrs. 47	last birthday) Yrs.		ays Ho			av. Year.			opia Opia
Usual Residence of 10a. State Md.	Decedent 10b. County Montq	omery		ity, Town or Loc		as					10	d. Inside City Limits
10e, Street and Num		anch Rd.	1		10f. Zip Co	ode				Ditizen of What	Countr	
11. Marital Status 1 Never Marri 3 Widowed	ied 2 Marrie	12. Was Deceden	?	l:	Vas Decedent	of Hispani Cuban, Me	xican, Puer	Specify Yes or No to Rican, etc.)		14. Race - A Black, W Specify B1	/hite, et	c.
(Spec		's Education t grade completed) College (1-4 or	5+)	(Give I	lent's Usual O kind of work d O NOT use ret	one during tired)	most of wo	orking	1	Kind of Busine	ess Indu	ustry
12				Unem	ploye					lone		
17. Father's Name (F Mohamme		st) Mohammed						me (First, Middle nish Ni				
19a. Informant's Na		o (Type, Print) - Friend						ur ⊉ Route Numb N.W.,Wa				
20a. Method of Disp	oosition	3 ☐ Removal from Stat	ہا ہ	Place of Dispo cemetery, crem Fird	sition (Name o	of r place)		Date 4 – 1 0	20c.	Location - City	or Tow	n, State
21. Signature of Par			the		Name and A	ddress of F	acility 41 Mortu	l1Kenne	dy	St,N. Jashin	W. gtc	on,D.C.
23a. Part 1. Enter the shock, or hear Immediate Cause (findisease or condition resulting in death)	rt failure. List on Final	omplications that caus ly one cause on each ii Aids a.	ne.		er the mode of	dying, suc	h as cardia	c or respiratory a	arrest,			Approximate nterval Between Onset and Death LS
resulting in death)		Due to (or a: Gastr		uence of): ympho:	ma						M	onths
Sequentially list cor if any, leading to im Cause (Disease or i that initiated events	mediate tying iinjury	b. Due to (or as	a conseq	uence of):								
resulting in death) L	_ast	Due to (or as	a conseq	uence ory:								
IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknowr	2 🔲 Fet at time of	al death 3	Ectopic preg Other (special					23d. Date of Month		y Day Year
		s contributing to death			nderlying caus		Part I.					cause of death?
syndro	ome							24a. Was auto perf	s an opsy formed?	prior	to com	sy findings available pletion of cause of
25. Was case referre	ed to medical				2	6 Place of	Death (Che	1 🗌 Yes	2 🔨	No 1 🗆	Yes 2	X -No
examiner? 1 Yes 2	€N°	Hospital:	tient 2 _	ER/Outpatien		Other:		Home 5 Res	idence	6 ☐ Other (S)	pecify)	
27. Manner of Death 1 Natural 2 Accident	5 Pending Investiga	ition		28b. Time of injury		Injury at work? 1 Yes	2 🗆 No	28d. Describe	how inju	ry occurred		
3 ∐ Suicide 4 ☐ Homicide	6 ∐ Could no determin				et, factory, of	fice		28f. Location (City or To		nd Number or e)	Rural R	oute Number,
(Check 2	Medical Ex.	Physician: To the best of aminer: On the basis of turse Practioner: To the	examinatio	on and/or invest	igation, in my o	opinion, dea	ath occurred	at the time, date	and place	e, and due to the	he caus	e(s) and manner stated
29b. Signature and t		Suparies	Ren	M MT		cense numb	5485	-		ate signed (Mo		
		no completed cause of					, , , , ,				+ -	

State Registrar

Certificate:

Medical

Barpara 31. Date filed (Month, Day, Year) JUN 07

Supanich, M.D.

32. Registrar Signature

Barbara

DHMH 17 Rev 7/2009

Barker

1500 Forest Glen Rd, Silver Spring, Md.

20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death . Time of Death 1. Decedent's Name (First, Middle, Last) 8:20 fM Moore **Physician** MON 30 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 1 / 16 / 1940 9. Birthplace (State or Foreign Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 XM 2 □ F 70 212-36-7354 NC Director Usual Residence of Decedent 10d. Inside City Limits Show 10a. State 10h County 10c. City, Town or Location or 28a-f shov notified at ¥ Yes 2 No MD Baltimore Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ö r items 23a or ner must be n 2036 Kennedy Avenue 21218 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Examiner 1 Yes %
If Yes, Give
Year or Dates: 1 Never Married 2 Married ye XNo Baltimore, Maryland 21215-0036 0 1 ☐ Yes 2 TNo Specify. Specify:Black by 3 Widowed 4 Divorced 'natural". Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Greenwood ith and Mental Hygiene. 27 is marked other than "r r traumatic event, the Med Elementary/Secondary (0-12) 12th College (1-4 or 5+) Auto Technician Auto Garage 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK Be Adell Moore ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Hazel Moore Important: If item 27 is any injury or other tra once. (Wife) 2036 Kennedy Avenue, Baltimore MD 21218 Health ; 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition ō 1

Burial 2

Cremation 3

Removal from State Stanislaus 6/5/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Weatherford Funeral Service 2431 E. Oliver Street, Baltimore, MD 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Lardlac disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if my sequentially list conditions, if my sequential cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to or as a consequence of physician and s the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 No Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe 2 No 3 Probably 4 Y Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 2 No 1 Yes 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 2 🗌 No 4 - Nursing Home 5 🗌 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation After Injury 1 🗌 Yes after death.

Director: Af
d in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours aff

To the Funeral DI

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number

2

State Registrar 31. Date filed (Month, Day, Year) 32. Regis

MELINDA MORTON

32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

B. Sparke

ORIGINAL

RES-000

May 30, 2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 5 Physician/ Nikolaos Mavros Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death **Examiner** psedale Bathmore quare aspital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days (Month, Day, Year) -13-1923 1 □MM 2 □ F 219-26-7812 Greece Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland Director 1X Yes 2 No Dundalk Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral USA 21222 3404 Yardley Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 X No 1 ☐ Yes 2X No Specify Specify: White Completed 3 XWidowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) during most of working and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Food & Beverage Tavern Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Unknown Unknown traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21204 permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Legal Baltimore Ave. 402, Mike Seganish-20a. Method of Disposition Suite Cuardia Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-4-2010 Baltimore, MD Cemeterv Lawn 22. Name and Address of Facility Bradley-Ashton Funeral Home Willow Spring Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death injarction Immediate Cause (Final Myo cardiaL ute Physician/ disease or condition Medical resulting in death) Due to (or as a consequent of): Examiner Ronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated several cause). Examine executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 Yes 2 No certificate 2 NO Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: s after death. al Director: After this colled in by the funeral directions 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check only one) 29b. Signature and tit of certifie 29c. License number 29d. Date signed (Month, Day, Year) my 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Regist 31. Date filed (Month, Day, State Registrar

Wes,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

3	-	1	1	-
2	6	D.m.	- 8	- 1
	- 1	7.3	- 1	١.
Ē	- 1	0	- 6	1

		_	State Registrar		Cer	tificate of Death	7	F	Reg. No.				
Р	hysicia	n/	1. Decedent's Name (First, Middle, Las	,			2.	Date of Dea Month	Day	Year	3. Time of Death		
	Medic	al		uise Milber	rry	<u> </u>		May	23	2010	10:54A ^M		
1	Examin	er	4a. Facility Name (if not institution, give			4b. City, Town, or Location			4c. Cou	nty of Death			
	uneral		5697 Purdue Ave. 5. Social Security Number 6. S		last birthday)	Baltime If Under 1 Year If Under	ler 24 Hrs. 8.	Date of Birth	1	g. Birthpl	ace (State or Foreign		
	irector		230-30-3376	DM OF TOTAL	89 Yrs.	Months Days Hours	Min.	Month, Day	0, 192	Countr			
ъ	T T		Usual Residence of Decedent 10a, State 10b. County	100.0	ity, Town or Loc	cation				10	d. Inside City Limits		
ırylan	a-f sh ïed a	양		100.0	nty, lowir or Loc				1 🔀 Yes 2 🗆 No				
e Ma	or 28g	Dire	Maryland 10e, Street and Number			Baltimore 10f. Zip Code			10a Citizen	of What Count			
vith th	23a c st be	ra	5697 Purdue A	ve. Ant. G3		21239	9			.S.A.	, y <u>.</u>		
eath v	tems er mu	Funeral Director	11. Marital Status	12. Was Decedent Ever in U	J.S. 13. V	Vas Decedent of Hispanic C f Yes, specity Cuban, Mexic		Yes or No-	14. F	Race - America			
ffer d	, or i	<u>ام</u>	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Yes 2 X No Specif		an, etc.)		Black, White, el			
	tural al Ex	ted	3 Widowed 4 Divorced	Year or Dates.					Spec	ртс			
72 hc	or resurt are western typester. Other traumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra	ade completed)	(Give I	lent's Usual Occupation kind of work done during me O NOT use retired)	ost of working	- 4	16b. Kind o	f Business Indi	ustry		
Vithin Vithin	the I		Elementary/Seconday (0-12)	College (1-4 or 5+)		nsed practica	al nurs	e	p:	rivate	duty		
nd i	d other		17. Father's Name (First, Middle, Last)			18. Mo	ther's Name (F	irst, Middle, N	Maiden Surn	ame)			
Value of the Ment	arked atic e	잍	Johnnie Sin	gleton			Li	zzie H	<u>lill</u>				
Show	7 is m raum		19a. Informant's Name/Relationship (T)	·		ng Address (Street and Num			•		<i>'</i>		
e, F	em 2		Deborah L. Morris 20a. Method of Disposition			Purdue Ave.				MD 21 on - City or Toy			
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after penartment of Health, and Mental Horiene	Important: If it any injury or o		1 X Burial 2 Cremation 3 C	Removal from State	cemetery, cren	natory or other place)	Date			•			
I Itin Pit. Pa	ortan injury		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Americal Service License			s Cemetery . Name and Address of Fac				indsor,	MD _		
Balti permit.	any and		Mathania O.	Hartler		301 Church St				MD 2177	'6		
			23a. Part 1. Enter the disease, or com	plications that caused the dea							Approximate		
Phy	sician/	X (3)	shock, or heart failure. List only o Immediate Cause (Final disease or condition	Pheum	MIL						Interval Between Onset and Death		
N	ledical	Ш	resulting in death)	a. Due to (or as a conse							- STIMM		
EX	aminer	_	Sequentially list conditions,	b							_		
p	sit	nin	if any, leading to immediate	Due to (or as a conse									
ecute	and I-trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a conse	quence of):						_		
18 / 60 tificate be executed	ng physician and as the burial-transit	g		la.									
8/6U	g phy: as the	Medical		· d									
D i	endine use	S 1	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr	nancy	Ectopic pregnancy			23d.	Date of deliver	ry I		
Geath of	ed for	Physician,	in the past 12 months? 1 Yes 2 No	4 Pregnant at time of	f death 5	Other (specify)				Month [Day Year		
ords, P.O. Box requires that the death	been signed by the attendi should be detached for use	Phy	9 Unknown Part II. Other significant conditions c		esulting in the u	nderlying cause given in Pa	art I	220 Did to	hacco use c	ontribute to the	cause of death?		
r. ≋ F. ∰	signed be d	qp	Tare II. Other Significant conditions of	ontributing to death but not he	southing in the d	nachying dadoc given in ra					ably 4 Unknown		
requir	should	etec						24a. Was a			sy findings available		
VITAL KECORDS, nysician: The law requires	ge 2 s	Completed						autop: perfor	sy med?	prior to com death?	pletion of cause of		
Y	ificate or, pa		25. Was case referred to medical			26. Place of D	eath (Check on	1 Yes	2 Mo	1 Yes 2	2 ∐ No		
VITE ysicia	s cert direct	To Be	examiner? 1 Yes 2 No	Hospital:	☐ ER/Outpatien	Other:	Nursing Home		ence 6 🗆 0	Other (Specify)			
ot F	ter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work?	28d	l. Describe ho	ow injury occ	urred			
On tendir	or Af	iţica	2 Accident Investigation 3 Suicide 6 Could not b	1		M 1 ☐ Yes 2	□ No						
DIVISION OF tal or Attending Ph rs after death.	ir by	Certificate:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Speci		eet, factory, office	28f	Location (St City or Town		mber or Rural F	Route Number,		
spital ours	filled		29a, Certifier 1 Certifying Physical Physics 1 Properties 1	sician: To the best of my kno	wledge, death o	occured at the time, date an	nd place, and d	ue to the cau	se(s) and ma	nner as stated			
e Hos	To the Funeral Director. After this certificate has I completed filled in by the funeral director, page 2 s	Medical	(Check 2 Medical Exam	iner: On the basis of examinati se Practioner: To the best of r	on and/or invest	tigation, in my opinion, death	occurred at the	time, date an	d place, and	due to the caus	se(s) and manner stated.		
To th	70 th	-	29b. Signature and title of certifier	1/ 2		29c. License number				nedy(Month, D			
			Mue Mes	not to		D004337	75	1	15/24	/2010	>		
			30. Name and address of person who of LALENUM. METUR	completed cause of death (Ite	m 23a) (Type, P	Printy DAT	IMINE	(11)	プラ	9			
	C.L.		31. Date filed (Month, Day, Year)	32. Fegistrar's Sign	ature •	NAD INITE	· · · · · · ·	(1997)	- (20	/			
	Stal Registra	7	JUN 0 7 2	010 Sineur	A. A	AVE PALT							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 23a per dr., g905.07/28/2010dhb Certificate of Death Reg. No. For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year Ku hales M 9 61: 5 200 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bal Li University acute If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign May 12, 1935 Days 1 XM 2 - F Months Hours Min. Yrs. Maryland Director 75 215-32-8971 Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hyglene. Is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State iral", or items 23a or 28a-f sho Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Tes 2 No Maryland Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 5440 Middleburg Rd. 21791 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 XNo If Yes, Give Year or Dates. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Specify. White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 milk truck driver transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic e once. Runalda Martin Ruth Buffington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen E. Martin/ wife 5440 Middleburg Rd. Union Bridge, MD 21791 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Beaver Dam Cemetery 6/3/2010 nr. Union Bridge, MD 21. Sign ur of Fareral Service License 22. Name and Address of Facility Hartzler Funeral Home Mune 011 Broadway Union Bridge, MD 21791 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Hemorrhagic Shock disease or condition resulting in death) Henor blagge Medical Due to (or as a conse vence of): **Examiner** Dieulafoy Lesion 6 weeds Sequentially list conditions, Examiner Drie to for its a consuctioned of cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Dav Year 2 No the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ᅙ 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy perform 2 🗆 No Yes 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ၉ 1 🗌 Yes 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at hin 24 hours after death. the Funeral Director; After 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 1💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29c. License number 150 lon mD MT194660 5/30/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Bultinone 21201 Bu St. Year Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State o	f Marylar	-	artment of F		and M	lental Hyg	giene	010	17512			
			Registrar 1. Decedent's Name (First, Midd)	lo l astl		Cer	tificate of L	<i>Death</i>			Reg. No.					
	Physicia	ın/		,	/l					2. Date of Dea Month	Day	Year	3. Time of Death 8:05 P ^M			
	Medic Examin		Carolyn 4a. Facility Name (if not institution		Murphy		4b. City, Town, or	Location	of Death	_May	26 2010 8:0 4c. County of Death					
	LAGIIII	ici	10525 Morning		,		Columbi		Dodan		Howard					
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under :		8. Date of Birth	nplace (State or Foreign					
	Director		370-20-8449	1 □ M 2 🔀 F	83	3 Yrs.	Months Days	Hours	Min.	Month, Day 11/27/	ntry) higan					
	nd now	_	Usual Residence of Decedent 10a. State 10b. Count	,	10c Ci	ty, Town or Loc	cation						10d. Inside City Limits			
	arylar a-f sl	ectc			i								1 X Yes 2 □ No			
	or 28	Ē	MD HOW To the street and Number	ira	l Co	lumbia	10f. Zip Code				10g. Citizen of What Country?					
	with t	Funeral Director	10525 Morning	Wind Lane			21044				U.S.					
	eath tems er m	문	11. Marital Status	12. Was Deced			Vas Decedent of Hi					. Race - Ameri				
36	72 hours after death with the Maryland "n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	亥	1 Never Married 2 🔀 Ma	If You City	2 🔀 No	1	Yes, specify Cuba			rican, etc.)		Black, White,	etc.			
Ö	ours a	Completed	3 Widowed 4 Divorce	Year or Da									hite			
5	72 hc n "na Aedic	훁	(Specify only high	ent's Education est grade completed)		lent's Usual Occupa kind of work done of O NOT use retired)		of workir	ng	16b. Kind	of Business Ir	ndustry				
212	within giene.		Elementary/Seconday (0-12)	College (1-	4 or 5+)	1	dit Manac	er			Ret	tail				
פַ	교육수명	B B	17. Father's Name (First, Middle,	Last)	***	0200	I I I I I I I I I I I I I I I I I I I		er's Name	(First, Middle, I						
<u>la</u>	d be Menta arkec	잍	Alfred	Siclo	an an			Mari	ie		Hai	ce				
Maryland 21215-0036	ge 1 and 2 should be file it of Health and Mental If item 27 is marked or or other traumatic eve		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Street a	nd Numbe	r or Rural	Route Number,	City or To	νη, State, Zip	Code)			
, S			Albert Murphy	/ Husband			5 Morning	Wind								
Jor	ge 1 a		20a. Method of Disposition 1 Burial 2 Cremation		State C	cemetery, crem	sition (Name of natory or other plac			ate		tion - City or T				
Baltimore,	it. Pa urtmer ortant njury		4 X Donation 5 □ Other		Ana	•	ts Registry					ver, Ma				
Ba	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility ANATOMY GIFTS DECISTRY 7500 LOCALETY DO STE. A. MANOVIZ 23a. Part 1. Filter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,													
			23a. Part 1. Enter the disease, of shock, or heart failure. List	r complications that ca	aused the deat	h. Do not ente	r the mode of dying	g, such as o	cardiac or	respiratory arre	est,		Approximate Interval Between			
-0	Priysician/	10	Immediate Cause (Final disease or condition	E	mohyse	ma							Onset and Death 30 years			
	Medical Examiner		resulting in death)	Due to (c	or as a conseq	uence of):							•			
		er	Sequentially list conditions, if any, leading to immediate			_										
	ed nsit	Examine	cause Disease or impury	Due to (c	Due to (or as a consequence of):											
	n and	Exa	that initiated events resulting in death) Last	C. Due to (c	C. Due to (or as a consequence of):											
9	cate be executed physician and sthe burial-transit	edical		d												
876	tificat ng ph as th		IF FEMALE:	1												
9 X	th cer ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months?		irth 2 🗌 Feta	aldeath 3 🗌	Ectopic pregnanc	у			230	d. Date of deliv	*			
Bo	ne death certifica the attending p shed for use as t	Physician/M	1 Yes 2 X No 9 Unknown	4 ☐ Pregn 9 ☐ Unkno	ant at time of o	death 5 ∟	Other (specify)					Month	Day Year			
Ö.	requires that the der been signed by the s should be detached	y Ph	Part II. Other significant conditi	ons contributing to de	ath but not res	sulting in the ur	nderlying cause giv	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?			
S, F	ires tl sign	d by	Breast Mass							1 🛚 Y	es 2 🗆 1	No 3 🗆 Pro	obably 4 🗆 Unknown			
ord	required shou	Completed								24a. Was a	n 2		opsy findings available			
ec	he lav te has age 2	mo								autops	med?	prior to co death? 1 \(\sum \) Yes	ompletion of cause of			
a F	an: T tifica' tor, p	e C	25. Was case referred to medical examiner?				26. Pla	ice of Deatl	h (Check	1 Yes	2 & No	L Yes	2 LALINO			
ξ	ysici lis cel direc	To Be	1 Yes 2 X No	Hospital:	npatient 2 🗆	ER/Outpatien	t 3 ☐ DOA Othe	r: 4 🗆 Nui	rsing Hon	ne 5 🗶 Reside	ence 6 🗆	Other (Specif	iy)			
o	fter thunderal	ate:	27. Manner of Death 1 Natural Natural Natural Natural	28a. Date o (Month	f injury , <i>Day, Year)</i>	28b. Time of injury	28c. Injury work	?		8d. Describe ho	ow injury oc	curred				
ioi	tendi death tor: A	Certificate:		gation not be				Yes 2 🗆	_							
Division of Vital Records, P.O. Box 687	or Ai after Direct d in by		4 Homicide determ	nined 286. Place of building	g, etc. (Specify	ome, farm, stre	et, factory, office		2	8f. Location (St City or Town		umber or Rura	al Route Number,			
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical	Physician: To the be Examiner: On the basis	of examination	n and/or investi	gation, in my opinio	n, death occ	curred at t	he time, date an	d place, and	d due to the ca	ause(s) and manner stated.			
	ro the vithin of the comple	ž	only one) 3 Certifying 29b. Signature and title of certifie	Nurse Practioner: To	o the best of m	y knowledge, d	eath occurred at the 29c. License	time, date	and place	, and due to the	cause(s) an	nd manner as s igned (Month,	tated.			
	-> - 0		Keisten (Clark 1	ns		D5396				40		, 2010			
	_		30. Name and address of person			23a) (Type, Pi		,		1	-	/				
R) V		Kristin Clark	, M.D. 501	8 Dors	ey Hall	Drive,	Ellic	ott	City, M	D 210)42 St	e. 104			
	Stat		31. Date filed (Month, Day, Year)	32. Re	strar's Signa	ture 8.	barker									
	Registra	ir .	JUN O	7 2010	crew	1. 19										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** June 2, 2010 2:45 ам Ellen. Jane Nolte /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Lutheran Village Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y NOV 4, 1 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🙀 F 1933 Maryland Yrs 76 213-32-3205 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at Westminster 1 ☐ Yes 2 X No MD Carroll Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21158 201 St. Mark Way Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrative Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maddox Jane Nolte Lucy Henry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type. Print) 7543 Main St., Ste 101, Sykesville, MD Robin L. Weisse-Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial 6/7/10 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears /Medical Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other clanificant conditions contributing to death but not resulting in the underlying cause given in Part I. **P** 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner Hospital: 1 ☐ Inpatient 1 ☐ Yes 2 No Other: ို 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛮 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 241 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) TANEY 32. Registrar's Signature 31. Date filed (Month, Day, Year)

JUN 0 4 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death . Time of Death Physician/ Frank H. O'Brien 0,200m Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sykesville Carroll Fairhaven Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country Days Min. Hours 90 0142574920 263-60-2592 Director Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Carroll Sykesville 1 🗆 Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 7200 Third Ave 21784 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 ▼Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 hand Mental Hygiene.
7 is marked other than "r 5+^{College (1-4 or 5+)} Elementary/Seconday (0-12) U.S. Navy Naval Officer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William E. O'Brien Elizabeth G. Hammond permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert O'Brien (Son) 704 Weybridge Circle Severna Park, Md. 21146. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State All County Cremation 06/05/2010 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel P.A P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 100M disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and s the burial-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 1 ☐ Yes 2 L g ☐ Unknown been signed by the should be detached 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law i within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 si autopsy performed Yes 2 2 🗆 No 1 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 2 XNo ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🔀 Natural 2 🔲 Accide 5 Pending 2 🗆 No 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Dav. Year) 34849

Registrar

DHMH 17 Rev 7/2009

State

1645 Libert

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June Angelo Anthony Onorato 2010 12:30 a^{M} Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Month, Day 1 🗶 M 2 🗆 F Days Hours Min. Mary land 219-05-1183 89 **Director** Yrs Aug. 1920 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Md. Baltimore Nottingham 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4300 Cardwell Ave. #307 21236 USA . Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes 2 □ No If Yes, Give filed within 72 hours after 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Services +4 Manager Be Maryland 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) t of Health and Mental I item 27 is marked o ၉ Page 1 and 2 should be Frank Onorato Marie Rose Tumenello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ruxton Green Ct. Towson, Md. 21204 Mr. Richard Onorato/ Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Parkwood Cemetery 20c. Location - City or Town, State Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 6-8-10 Baltimore, Md. 4 Donation 5 Other (Specify) . Signature of Funeral S 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson. Md. ervice 23a. Part 1. Enter the diseast or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CHRONIC OBSTRUCTIVE PULMONARY DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, Dunito (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NO Other (Specify) HOSPICE ည 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural in 24 hours after death.
in 24 hours after death.
ihe Funeral Director; Aft 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

JONE

ONORATO

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Leslie Pennington May 2010 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shepherd's Glen Assisted Living <u>Carroll</u> Taneytown If Under 1 Year If Under 24 Hrs Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 19<u>12</u> Dec. 16 Country Maryland 1 🛛 M 2 🗆 F Days Hours 97 **Director** 214-01-2948 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Director 1 ☐ Yes 2 X No MD Taneytown Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4949 Middleburg Rd 21787 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ۵ 1 Never Married 2 Married ☐ Yes 2 XNo Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", Specify: White Completed 3 X Widowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal Govt. Proof Reader Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Theresa F. Edler Abraham Pennington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11928 Beaver Dam Rd. Union Bridge, MD 21791 Dean Pennington/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Demoval from State 4 ☐ Donation 15 ☐ Other (Specify) All County Cremation 6/1/10 Sykesville, MD . Signature of ral Serv 22. Name and Address of Facility Hartzler Funeral Home Union Bridge, MD 21791 Broadway 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Brugger Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consec To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) assisted Other: 1 🗆 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work' 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of contifier 30. Name and address of person who completed or

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Registrar's Signature

	1 - For Amend Item Registrar 1. Decedent's Name (First, Middle, L.	6/9/10 TT 6/9/10 TT 26 tate of Maryla	Certifica	te of Death	Reg. 2. Date of Death	/ 1 / 1 / 1	3. Time of Death			
Physician/ Medical Examiner	Edward 4a. Facility Name (if not institution, gin	Jacob 1	Patter 4b. Cit	y, Town, or Location of Dea	Month 2	Day Year 2010 4c. County of Death	12:42 A M			
	Sinai Ho.	spital of b	Elhmore	Galh'm der 1 Year If Under 24 Hi		17/10/45 - 5:11	(2)			
Funeral Director		Sex 1 X M 2 □ F	5 Yrs. If Unc		8. Date of Birth 17 1. Aronth, Day, Yea	945 945	pace (State or Foreign ary and			
ne Maryland or 28a-f show notified at	T	10c. (Baltin	nore		1	0d. Inside City Limits			
leath with the trems 23a or 2 er must be no Funeral Di		32nd 5tr	eet 10f. Z	Zip Code 2/2/8	10g.	Citizen of What Cour	A			
. ?	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in I Armed Forces? 1	If Yes, sp	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue 2 M No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Americ Black, White, Specify:				
21215-0036 within 72 hours after ger than "natural", o the Medical Exam , the Completed by	15. Decedent's (Specify only highest (Elementary/Seconday (0-12)	Education	life. DO NOT u	vork done during most of w use retired)	orking 16b	. Kind of Business In	dustry			
land 2. The filed with lental Hygie riked other itic event, the land the land the land the land the land the land land land land land land land land	17. Father's Name (First, Middle, Last	Patterson	Correc	18. Mother's N	ame (First, Middle, Maide	en Surname) SCOH				
Ma 12 shoulth an old the and t	19a. Informant's Name/Relationship Tamara Pa		19b. Mailing Addre	Parklawi	Rural Route Number, City	1 . (ore MD zi			
O O *- 1	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐ Removal from State	D. Place of Disposition (No. cemetery, crematory of	ame of rother place) OVES + 6	Date 20c -4-10 00	Location - City or To Wings Mi	own, State			
Baltimo permit. Page Department Important: I any injury or once.	21. Signature of Funeral Service Lice	. Theene	22, Name Va U 5/5	and Address of Facility 19hn C. GI 1 Baltimo	reene Fundation	eral Se	NICES (21229			
Physician/ Medical Examiner	23a. Part 1. Epts the disease, or co shock, or heart fallure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that caused the devone cause on each line. a. Due to (or as a const	tatic adu	enal Canc			Approximate Interval Between Onset and Death			
50 te be executed sysician and be burial-transit dical Examiner		C. Due to (or as a consequence of): d.								
Division of Vital Records, P.O. Box 6876(Hospital or Attending Physician: The law requires that the death certificate 24 hours after death. Funeral Director, After this certificate has been signed by the attending physicated filled in by the funeral director, page 2 should be detached for use as the edical Certificate: To Be Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of preg 1 Live Birth 2 Fequency 4 Pregnant at time of 100 Unknown	etal death 3 🗌 Ectopi	ic pregnancy (specify)		23d. Date of deliv Month	ery Day Year			
Is, P.O. Lires that the signed by all doe detailed be detailed by PI	Part II. Other significant conditions	contributing to death but not		g cause given in Part I.		co use contribute to t				
Records, The law requirer rate has been sig page 2 should b					24a. Was an autopsy performed 1 Yes 2	prior to co	psy findings availab impletion of cause of 2 No			
Vital Reysician: The social scentificate director, pag	25. Was case referred to medical examiner?	Hospital:		26. Place of Death (C	heck only one)					
n of Vii ling Physic Affer this of funeral dire		1 X Inpatient 2 28a. Date of injury (Month, Day, Year)	ER/Outpatient 3 28b. Time of injury M	28c. Injury at work? 1 Yes 2 No	Home 5 Residence 28d. Describe how in		<i>(</i>)			
Division of Vital Records, To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director After this certificate has been sig completed filled in by the funeral director, page 2 should b Medical Certificate: To Be Completed	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	t be 29e Place of Injuny - At	home, farm, street, fact		28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,			
the Hospital in 24 hours the Funeral Inpleted filled	29a. Certifier (Check 2 Medical Exa	hysician: To the best of my knuminer: On the basis of examinations of examinations of the best of the	tion and/or investigation,	in my opinion, death occurre	ed at the time, date and pl	ace, and due to the ca	use(s) and manner s			
To the within 2 To the comple	29b. Signature and title of certifier	to completed cause of death (II	M.D. 2	9c. License number RES 0	29d.	Date signed (Month,	Day, Year)			
	711	o completed cause of death (I	tom 22a) (Type Print)	1(2)	1 .	8	Whyman MA			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			1 - For State Registrar	State of	Maryland / De <i>C</i>	partment of ertificate of		Mental Hy	/giene	0 17518
			1. Decedent's Name (First, Mi	ddle, Last)				2. Date of D		3. Time of Death
·2	Physic /Medi		Lester	Earl	Pitts			5-30-	2010	12:30a ^M
The same	Exami		4a. Facility Name (If not institu		•	4b. City, Town, o	or Location of Dea	th	4c. County o	f Death
7			Washington 5. Social Security Number				a park		Monte	gomery
	Funeral Director		249-88-5815	1 M 2 □ F	Age (In yrs. last birthda 56 Yrs.	Months Days		(Month, D		Birthplace (State or Foreign Country)
			Usual Residence of Decedent		30			10-30	-1953 3	South Carolin
	rylan show	_	10a. State 10b. Cour	,	10c. City, Town or					10d. Inside City Limits
	r 28a-f show	Director		ce George	CI	Inton				Y□Yes 2□No
	ath with the 23a or 2		10e. Street and Number			10f. Zip Code			10g. Citizen of WI	hat Country?
	eath w	era	7410 Clinto	12. Was Decede			735	Procify Voc or N	USA	- American Indian.
10	hours after death with the Maryland tural", or items 23a or 28a-f show at Everriner must be notified at	Funeral	1 ☐ Never Married 2 ☐ M	Armed Force	TINO -	B. Was Decedent of If Yes, specify Cub	oan, Mexican, Puer	to Rican, etc.)	Black	, White, etc.
5-0036	urs aff	þ	3 ☐ Widowed 4 ☐ Divorc	lf Yes, Give ged Year or Dat	3÷-21-74	1 □Yes 2 No	Specify:		Specify:	Black
5-0	72 hours 'natural'', dical Eve	Completed	15. Deced	dent's Education thest grade completed)	16a. Dec	cedent's Usual Occu	pation	rkina	16b. Kind of Bus	•
2121	vithin ne. han "	Id II	Elementary/Secondary (0-12		UI D+1 1 .	ve kind of work done DO NOT use retire nter	ed)	9	Govern	ment Printing
2	be filed wil stal Hygien of other th event, the	ပ္သ	12 17. Father's Name (First, Midd	lle l ast)	FLJ	.11061	18 Mother's Na	me (First Middle	e, Maiden Surname	
an	d be i ental ced o	To Be	Ghette Whee					na Piti		,
Maryland	2 should be filed v and Mental Hygid is marked other i aumatic event, the	F	19a. Informant's Name/Relation	onship (Type. Print)	19b. Ma	iling Address (Stree				State. Zip Code)
	nd 2 alth a 27 is er tra		Nelson Pitt	s- Brother	I					aryland20735
ore,	of He		20a. Method of Disposition		20b. Place of Dis	position (Name of ematory or other pla	ace)	Date		City or Town, State
ī	Page ant: II		X ☐ Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		"Glenwoo	d Cemet	• 6-/	-	_	gton,D.C.
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke any injury or other traumatic once.		21. Signature of Funeral Servi	ce Licensee	ate u	22. Name and Addre	ess of Facility41 1 Mortu	1Kenned ary Ind	dy St,N.	.W. ngton,D.C.
			23a. Part 1. Enter the disease, shock, or heart failure. L	or complications that cau	sed the death. Do not e					Approximate Interval Between
-	Physician		Immediate Cause (Final disease or condition	Cara	ionospir	or Fory	Arres	1		Onset and Death
4	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):	1 /				
	<u> </u>	<u></u>	Secuentially list conditions	b. Due to /o	as a consequence of):	hock				
	nsit	ij	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	3 July 10 (0)		TSOL	acomia.			
<u>,</u>	execunate and	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consequence of):	1000	141100			
8760,	cate be executed ohysician and the burial-transit			d. Ather	osclant	Iscl Te Cardo	ovasa	clar D	isquig.	
68	rtifica ng ph as th	ledi	IF FEMALE:					. *		
Box	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rall director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1 ☐ Live birt		☐ Ectopic pregnan	CV			of delivery
0	he dea the a	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnar 9 ☐ Unknow		Other (specify)			Mon	th Day Year
9.	ires that the de signed by the a I be detached f		Part II. Other significant cond	litions contributing to deat	h but not resulting in the	underlying cause giv	ven in Part I	23e Did	tobacco use contrit	oute to the cause of death?
of Vital Records,	sign d be	Completed by	Congustin	Hond Fo	rilune. N	Y stage	IV			3 Probably 4 ☐ Unknown
Sor	w require s been si should t	lete	Mukastati	Partata	- carrin	1		24a. Was		
Re	sician: The law s certificate has b irector, page 2 si	E C	12:200	1 10000000	- Caran	nont		auto	psy pr	ere autopsy findings available ior to completion of cause of eath?
tal	an: T tificat or, pa		25. Was case referred to media	o artu i	massine	USCIP	Of Diamet De	1 □ Yes	2 72 No 1	□Yes 2 🙀 No
>	hysicia this cer al direct	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	atient 2 ☐ ER/Outpati	ent 3 DOA Oth		ath <i>(Check only</i>	idence 6 ☐Othe	(Specify)
ō	ding Physician: The Interpretation of After this certificate his funeral director, page	Ë	27. Manner of Death 1 ■ Natural 5 □ Pend	28a. Date of				T	how injury occurred	
ioi	Attendir death. ctor: Af y the fur	atio	2 ☐ Accident inves	stigation	Day, Tear)		Yes 2 □No			
Division	cal or Att	Certification: To	3 ☐ Suicide 6 ☐ Coul 4 ☐ Homicide dete	rmined 28e. Place of	Injury - At home, farm, s etc. <i>(Specify)</i>	treet, factory, office		28f. Location City or To	Street and Number wn, State)	r or Rural Route Number,
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Medical	29a. Certifier 1 Certification (Check only one)	ying Physician: To the be al Examiner: On the basi and manner	s of examination and/or	ath occurred at the t investigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) and mar , date and place, ar	nner as stated. nd due to the cause(s)
	To t To t	Σ	29b. Signature and title of certific	fier		29c. Licens				(Month, Day, Year)
	, ,		1	M		4	7867		May 13.	14/2010
	Le V		Oncy sun	on who completed cause of	Randolph	Print) Pd # Z1	6. Rock	wille,	MD ZO	0852
	Sta Registr		31. Date file (Month, Day, Yea	0 7 2010 22	etrar's Signature	park		t .		
E 1 15					- 7	# ·				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month 2010 08:52 PM Kobv Porta Medical Tune 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Day, NOV • 28, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Hours 1 🔀 M 2 🗆 F Maryland Director 219-34-1670 72 Yrs. Nov. Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo Perry Hall Maryland Baltimore 10e, Street and Number 10g. Citizen of What Country? Funeral 21128 4503 Dunton Terrace, U.S.A. Unit D 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Loan Officer Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vincent Mills Frank Porta Mav 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26101 Parkersburg, West Virginia 10 Westwood Drive Gregory M. Porta 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 1

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 6-9-2010 Timonium Maryland Signature of Euneral Service Licensee Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 22. Name and Address of Facility 1050 York Road 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on a cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiomyopath Ischemic disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Day Pregnant at time of death 1 Yes 2 L g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated United States of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

within 24 hours a

To the Funeral Completed filled

18 State Registrar

31. Date filed (Month, Day, Year)

FARDAD SARABCHI

tasdas Sasal

only one)

2012. University 32. Registrar's Signature

MU 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Department of Medicine

AT-2438946

Pkus

29d. Date signed (Month, Day, Year)

Union

Baltimore

Memoral

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #17, per FH G904 6/7/10 TT
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A M Medical Racility Name (if not institution, give street and number) **Examiner** 4c. County of Death KaltiMore 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 1 □ M 2**X** F Min. Hours Director Yrs. permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a State 10b. County City, Town or Location 10d. Inside City Limits **Funeral Director** 1 🗆 Yes 2 🗙 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes, 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) ministrato Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ - Thomas A Ryles Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other pla Date 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Name and Address of Facility 087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the node of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between nset and th Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DERTENSION mona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month ate has been signed by the page 2 should be detached 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 1 Other: 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 🗌 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Nes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Sign re and title of certifie Name and address of person cause of death (Item 23a) (Type, Print) CHARLES ST. 31. Date filed (Month, Day, Year) 32. Re State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1:27 A Obinson Medical 4a. Facility Name (if not institution. Examiner 4c. County of Death Baltimore arkville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Security Number Months Days Min. Yrs. Director , or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at **Funeral Director** Baltimore 1 🗆 Yes 2 📈 No tarkville 10e. Street and Numbe 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced to lack Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. QO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 1achinist Be 17. Father's Name (First, Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) ည trobinson 19a. Informant's Name/ lejationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1224 lother Important: If item 2 any injury or other once. 20a. Method of Disposition
1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date treenmount 4 Donation 5 Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Mo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) Medical Disho (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence oi): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year been signed by the 9 Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has by page 2 s autopsy performe Yes 2 X No 1 🗌 Yes within 24 hours after di ath.

To the Funeral Direct. r. After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other 2 2 🗌 No 1 Inpatient 2 Impatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 1 Natural 28d. Describe how injury occurred 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Sian 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State s Signature Registrar

DHMH 17 Rev 7/2009

AZ

12

CONSMICON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Physician/ Month May 201 AM FRANCES MEHRING 6:22 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
June 28, 1925 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Country)
Marvland Director 216-22-9821 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Carroll Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6790 Middleburg Rd. 21757 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) clothing co. seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Nellie Lookingbill Charles Mehring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Bowers/daughter 6803 Middleburg Rd. Keymar, MD 21757 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Haugh's Cemetery 6/4/2010 4 ☐ Donation 5 ☐ Other (Specify) Ladiesburg, MD 21. Siyna /r y uneral Service 22. Name and Address of Facility Hartzler Funeral Home Union Bridge, MD 21791 Broadway 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory ar Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Kau

31. Date filed (Month, Day,

arkel

Frederick, mD 2170

ath

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend Item 1 per dr., 2904,06/16/2010dhb
Amend Items 24a,25,26 per dr., 2904,06/16/2010dhb

Amend Items 24a,25,26 per dr., 2904,06/16/2010dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Henry James Sliver John Henry Sliver May 2010 4:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 905 Topview Drive Edgewood Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 X M 2 □ F 216-44-0221 64 Jan 15, Director 1946 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ed other than "natural", or items 23a or 28a-f shovevent, the Wedical Examinar must be rediffed at MD Harford Edgewood Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 905 Topview Drive 21014 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1966 – 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. within 72 hours after 1 ☑ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 'natural", or Specify: White 1 ☐Yes 2X No 2 1968 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation un 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked other than any injury or other traumatic event, Impore. 12 home improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mable Blackaby 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 905 Topview Drive; Edgewood, Maryland 21014 Kathy Ann Sliver/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ₺ Other (Specify) in State 21. Signature di Funeral Service 22. Name and Address of Facility
State Anatomy Board; 655 W. Baltimore Street S Wade Birector 23a. Parl I. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lmmediate Cause (Final disease or conditions) Approximate Interval Between Onset and Death COPD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MOKING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed sician and burial-trans Due to (or as a consequence of) Box 68760. physician Physician/Medical the attending | IE FEMALE: use a 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy ģ in the past 12 months? Month Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 HACELLENIION 1 2 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 1 ☐ Yes 1 □ Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 XNo Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital
within 24 hours a
To the Funeral I
completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Continued in the cause of the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) help w Helper mo 5/14/10 10550803 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHILLE WE HAWTERD 10138101 61 JUJIH

State

Registrar

31. Date filed (Month, Dav. Year)

JUN 07

37 Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Elizabeth D. Scweitzer 3:20 PM 05 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore ManorCare Towson Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Date of Birth (Month, Day, 1 □ M 2 □ XF Months Days Hours Min. 16-09-244 MD 94 06/29/1915 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County MD Baltimore Director Towson 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 507 East Joppa Road USA 21286 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married ģ If Yes, Give Year or Dates: 1 □Yes 2√No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker UNK 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be UNK UNK ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dept. Of Health (Dorsey 611 Central Ave. Towson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn, MD 4□Donation 5♥Other (Specify) Intom. Lorraine Park 5/21/10 21. Signature of Juneral Service Licensee 22. Name and Address of Facility 2829 Hudson Street, Skarda Funeral Home Baltimore, MD, 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Physician/Medical Examiner Be Completed by Medical Certification: To

Examiner Attending Physician: The law requires that the death certificate be executed burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the burial signed by the a certificate has been s rector, page 2 should funeral director, To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A completely filled in by the fu

Funeral

Director

la or 28a-f show

ns 23a

ò

Department of Health Important: If Item 27 any injury or other transce.

hysician /Medical

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Immediate Cause (Final disease or condition resulting in death)	a. CEREBROVA	ASCULAR 7	HROM BOSI	Onset and Death
	Due to (or as a consequence of):	KE		Weeks.
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
resulting in death) Last	Due to (or as a consequence of):			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 Mo 9 □ Unknowh		topic pregnancy ner (specify)	23d. Date of d Month	lelivery Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underl	ying cause given in Part I.	23e. Did tobacco use contribute 1 Yes 2 No 3	to the cause of death? Probably 4 Unknown
			autopsy prior to performed? death	autopsy findings available o completion of cause of ?
25. Was case referred to medical examiner?		26. Place of Death	(Check only one)	
1 Yes 2 XNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 Nursing Hom	e 5 ☐ Residence 6 ☐ Other (Sp	pecify)
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury		3d. Describe how injury occurred	
3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, f building, etc. (Specify)	factory, office 28	3f. Location (Street and Number or City or Town, State)	Rural Route Number,
29a. Certifier (Check only one) 1 Certifying Pr	yslcian: To the best of my knowledge, death occ niner: On the basis of examination and/or investi and manner stated.	curred at the time, date and place, a gation, in my opinion, death occurre	nd due to the cause(s) and manner d at the time, date and place, and d	as stated. ue to the cause(s)
29b. Signature and title of certifier	> 1	29c. License number	29d. Date signed (Mo	nth, Day, Year)
· 1110	h boly	D-12849	5-17	-10
30. Name and address of person who	completed cause of death (Item 23a) (Type, Print 0), 7600	OSLER Dr.	TOWSON M	10 21204

State Registrar

31. Date filed (Month. Day. Year)

DHMH 17 Rev 1/2001

M.D 32. Registrac's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #25 & 27 per ME G904 6/7/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day May 23 Robert Hollis Smith II 2010 Medical 7:30 P^M 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Luth. Village Hlth. Care Ctr Carroll Westminster 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Date of Discourse (Month, Day, Year 16, 1 🛛 M 2 🗆 F Days Months Hours Min. Year Director 212-06-0141 38 Yrs. Marvland Dec. 1971 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct Carroll Maryland Westminster 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 75 Smith Rd. 21158 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 l and Mental Hygiene. Is marked other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 disabled disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert H. Smith Mary Ellen Zile permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Smith/ father 75 Smith Rd. Westminster, MD 21158 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pipe Creek Cemetery 5/26/2010 nr. Linwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Due (or as a consequence of): Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed use (Discase or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Year signed by the at a be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ & Begardan Meywene Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/X/N 1 ☐ Yes 2 ☐ No after death.

Director: After this certification by the funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury 28d. Describe how injury occurred Riving 95 Pussenger in 3 wheelengcoden 27. Manner of Death Certificate: 28b. Time of 28c. Injury at Hospital or Attending 1 Natural 2 Accident 5 Pending 14.00 M work? 1 🗆 Yes 2 🗖 No 3-9-1986) Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 5 34 5 m. 49 Rd completed filled in by determined tarum Medical 1 Certifying Physician: To the best of my prowledge, death of cored at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or in estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/o 3 Certifying Nurse Practioner: To the best of my know (Check death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23) (Type, Print) Aberender Bordes State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Year SAPOUNAKI (SENEVIEVE 0100 CINE 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore City 901 S. Oldham Street If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💆 F Yrs. 95 Director 11-27-1914 Greece 213-07-0901 Usual Residence of Decedent a or 28a-f show t be notified at 10c. City, Town or Location 10a. State 10d. Inside City Limits Director 1 XYes 2 □ No Baltimore City MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 "natural", or items 23a o 901 S. Oldham Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗵 No Specify. Specify: ģ White 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 12 should be filed w h and Mental Hygier 7 Is marked other th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Maria Kolaria Nicholas Karagiannis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Sapounakis - Daughter 901 S. Oldham Street, Baltimore, MD 21224 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Greek Orthodox Cem 6-5-10 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn, MD 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licens Hall 2134 Willow Spring Road, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** DEMENTA /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or Irijuly that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed and burial-tran Due to (or as a consequence of): Box 68760. attending physician Physician/Medical the IF FEMALE nse 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for 1 in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate 2 ☑No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation Injury within 24 hours are:
To the Funeral Director: A 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D62032 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER HAYASHI 5505 HOPKINS BAYVIEW CIRCLE BALTIMORE, MD 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep 1 - State Amend Item 30 per nh, g904,06/	partment of Health and M 07/2010dhb Prificate of Death	ental Hygie Re	ene g. No. 2010	17627			
	Physicia Medic		1. Decedent's Name (First, Middle, bast) MAL SUSSMAN		2. Date of Death	24/2090	3. Time of Death			
	Examin	er	4a. Facility Name (if not institution, give street and number) MILFORD MANOR NURSING HOME	4b. City, Town, or Location of Death PIKESVILLE	,	4c. County of Death BALTIMORE				
	Funeral Director		5. Social Security Number 218-16-1162 6. Sex 1 M 2 M F 7. Age (In yrs. last birthday) 98 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y 08/10/1	9. Birti	nplace (State or Foreign ntry) LITHUANIA			
	faryland 3a-f show iffied at	ector	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Li			10d. Inside City Limits 1 🛣 Yes 2 □ No				
	ith the M 23a or 28 st be not	Funeral Director	10e. Street and Number	10f. Zip Code 21215	10	g. Citizen of What Country?				
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		7015 PARK HEIGHTS AVENUE 11. Marital Status 1	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:						
Maryland 21215-0036	within 72 hou giene. ier than "natu is, the Medica	Completed by	(Give	edent's Usual Occupation kind of work done during most of worki DO NOT use retired) SALES	ing	16b. Kind of Business Industry BARISH GOWN SHOP				
land	l be filed fental Hy rked oth tic event	To Be	17. Father's Name (First, Middle, Last) SAMUEL SUSSM	THE STATE OF THE S	e (First, Middle, Ma		NBERG			
, Mary	nd 2 should I salth and Me n 27 is marl er traumati		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rura 1 RED CEDAR PLACE,						
Baltimore,	Page 1 and ment of Heal ant: If item 3 ury or other			osition (Name of ematory or other place) ABRAHAM CONG. 05/26		Oc. Location - City or ROSEDAL				
Balt	permit. Page Department Important: I any injury o once,		21. Signature of Funeral Service Licensee	22. Name and Address of Facility SOL 8900 REISTERSTOWN						
-	Physician/ Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause hine. Immediate Cause (Final disease or condition resulting in death) a. De to for as a consequence on:		-		Approximate Interval Between Onset and Death			
	Examiner	er	Sequentially list conditions, b. 28 ilify							
	ate be executed ohysician and the burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (ursease or impory that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):							
3760	ificate be ig physic as the bu	Medical	d			+				
. Box 687	ne death certificate be executed the attending physician and ched for use as the burial-transi	Physician/Me	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deli Month	very Day Year			
ds, P.O.	Hospital or Attending Physician: The law requires that the dee 24 hours after death. Funeral Director: After this certificate has been signed by the sted filled in by the funeral director, page 2 should be detached in by	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		3e. Did tobacco use contribute to the cause of deat				
Division of Vital Records,	'sician: The law ree certificate has be lirector, page 2 sho	Completed			24a. Was an autopsy performe	prior to c death?	opsy findings available ompletion of cause of 2 No			
/ita	sician: certific irector,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: I I I I I I I I I	26. Place of Death eck						
on of V	ial or Attending Physician: Ti s after death. al Director: After this certificat ed in by the funeral director, p	Certificate: To	27. Mann of Death 1 Inpatient 2 ER/Outpatie 28a. Date of injury (Month, Day, Year) 2 Accident Investigation	, 1	me 5 ∐ Residen 28d. Describe how	ce 6 Other (Special injury occurred	<u> </u>			
Division	tal or Atters after de al Directo ed in by the		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,			
)	To the Hospital of within 24 hours a To the Funeral D completed filled in the following the following the following the following for the	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death dedical Examiner: On the basis of examination and/or inversion only one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at	the time date and	place, and due to the c	ause(s) and manner stated			
	To t with To tl		29b. Signature and Atlantic continer CLaw	29c. License number RO 88852	290	Date signed (Month,	Day, Year)			
	かく		30. Name and address of person who completed cause of death (Item 23a) (Type, Kathleen Diamond, 2835 Smith Avenu		. 1	,				
	Stat Registra		31. Date filed (Month, Day, Year) 32 Registrar's Signature							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $\angle \cup \cup \cup$ Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day June 2010 Dolores Marie Siegmund 5:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Manor Care Towson Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Maryland Days 1 □ M 2 □**X**F July 12, 1922 Months Hours Min. 212-01-6853 87 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at , Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In terms 27 is marked other than "natural", or items 23a or 28a-f sho lury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🙀 No Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21093 105 Othoridge Road USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 🗆 Yes Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: white If Yes, Give 3 ¥ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kasmir Wojciechowski Marie Kazmierczak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Paul B. Siegmund 105 Othoridge Road; Lutherville, MD 21093 son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 4 ☐ Donatio 5 ☐ Other (Specify) Rosary Cemetery 6/8/2010 Baltimore, MD 1050 York Road 21. Signature of 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 nons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final Physician/ Izheimers disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autop-performed: 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 2 🖎 No မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) un 00061199 June, 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 57, Suite 4105 Touson MO 21204 701 Worth Charles 32. Registra s Signa

State Registrar

			For State Registrar	State of Maryland / Depa <i>Cer</i>	artment of Health and N rtificate of Death		ene i. No. 2010 17629
	Physici /Medic		1. Decedent's Name (First, Middle, Last) BABY BUY THUMA	15		2. Date of Death Month	Day Year CHO PM
	Examir		4a. Facility Name (If not institution, give str MENCY MEDICAL CL		4b. City, Town, or Location of Death BALTMINE		4c. County of Death BALTIMENE
	Funeral Director		IV IP	7. Age (In yrs. last birthday) Yrs.	9. Birthplace (State or Foreign Country)		
	ne Maryland 8a-f show	ector	Usual Residence of Decedent 10a. State 10b. County MD 5altio	10c. City, Town or Lo	0(2		10d. Inside City Limits 1 ☐Yes 2 ∑No
	h with the 23a or 2	al Dire	10e. Street and Number	= Wa.	10f. Zip Code 21234	10g	g. Citizen of What Country?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madcal Examinar must be notified at	by Funeral Director	11. Marital Status 12 1 Mever Married 2 Married 3 Widowed 4 Divorced	1 ∏Yes 2 XNo	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify:
21215-0036	in 72 ho "natur	Completed	15. Decedent's Educa (Specify only highest grade of	life I	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing	Sb. Kind of Business/Industry
	led withi lygiene. her thar		Elementary/Secondary (0-12)	College (1-4or 5+) NA	NIA		NIA
lanc	ald be fill Aental H rked ott tic ever	To Be	17. Father's Name (First, Middle, Last)	0 5	18. Mother's Nam	The came s	
Maryland	12 shouth and No. 7 is ma		19a. Informant's Name/Relationship (Type	/	ng Address (Street and Number or Ru		
	ss 1 and 2 of Health item 27 i		20a. Method of Disposition	S /mo+ther 99 S 20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)	Parke 20	Oc. Location - City or Town, State
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any injury or other to ODC.		1 ☑ furial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)			0-10 1	Bath more mo saton Funcial Home
Ba	Depa Depa Impo any ir		21. Signature of Funeral Service Licensee	- P,	4. 2134 Willow S	shey-Hs	SCHON FUNERAL /HERR
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.	er the mode of dying, such as cardiac	or respirm ry arres	t, Approximate Interval Between Onset and Death
	ed sit	niner	Sequentially list conditions, if an leadin to immediate cause. Enter Underlying Cause (Disease or injury	Due to or as a consequence of:			
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of)			
	Hospital or Attending Physician: The law requires that the death certifics 24 hours after death. Funeral Director: After this certificate has been signed by the attending phately filled in by the funeral director, page 2 should be detached for use as the funeral director.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
ords, P.	w requires that s been signed b should be deta	β	Part II. Other significant conditions contr	ibuting to death but not resulting in the ur	nderlying cause given in Part I.	23e. Did toba 1 □ Yes	ccc use contribute to the cause of death?
of Vital Records,	ician: The law r certificate has be ector, page 2 sh	Completed	OF Was seen referred to medical				Mo 1 □ Yes 2 No No
fVii	Physician: this certifical	Fo Be	25. Was case referred to medical examiner? 1 Yes 2 No	spital: 1 XÎnpatient 2 ☐ ER/Outpatier	Other	th <i>(Check only one)</i> ome 5 ☐ Residen	ce 6 Other (Specify)
sion o	Attending Ph death. ctor: After th y the funeral	Certification: To	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	f 28c. Injury at Work? M 1 □Yes 2 □ No	28d. Describe how	injury occurred
Division	al or Attendl s after death. al Director; A ed in by the fu	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, str building, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my knowledge, deather: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the car rred at the time, dat	use(s) and manner as stated. ie and place, and due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier Mush noly	an MESIDENT PHYSICIAN	29c. License number PRR911 Print) HERCY Hospital	290	d. Date signed (Month, Day, Year) 05/24/2010
				pleted cause of death (Item 23a) (Type,	Print) 1 & RCY Hospital -	301 ST.	Paulst. 21202
	Sta Registr		31. Date filed (Month, Day, Year)	32. Heastrar's Signature	parked		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#8perFH, G904, 6/10/2010, WS
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year ا (ج P Medical 4a. Facility Name (if not institution Examiner 4b. City. Town, or Location of Death 4c. County of Death last birthday) Sex If Under 24 Hrs. 8. Date of Birth -22-1942 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗸 F Months Hours Min. Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or Items on other traumation. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show Injury or other traumatic event, <u>the Medical Examiner must be notified at</u> 10b. County 10a. State City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Kes 2 No 10e. Street and Number 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. as Decedent Ever in LLS 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 2 No Yes 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT page retired) College (1-4 or 5+) Be Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden ٥ 19b. Mailing Address (Street and Number or Rural Route Number, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service VI QU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, DENOCARCINOMA TA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year cate has been signed by the a page 2 should be detached f g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director; After this certificate 2 🗌 No ☐ Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work 1 Tyes 2 🗌 No Investigation 6 Could not be Accident filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗔 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of pe rson who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32. gistrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2010 Month Year **Physician** Mattie Pearl Williams May 30, 1:40a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Homewood Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2 🗷 F 74 212-34-7418 Director 04/25/1936 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10c. City. Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☑ Yes 2 ☐ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2610 East Oliver Street 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: Black er than "natural", c 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If item 27 is marked other this any injury or other traumatic event, the ODGE. 8th <u>Housekeeper</u> Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Earl Williams Hattie Jordan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah Wilmer (Daughter) 2610 E. Oliver Street, Baltimore MD 21213 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Trinity Cemetery 6/4/2010 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Weatherford Funeral 21. Signature of Fyneral Service Licensee Service 2431 E. Oliver Street,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2431 E. Oliver Street, Baltimore MD Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and-trar Due to (or as a consequence of): burial-Box 68760, attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o ed by the 9 Unknown 9 ☐ Unknown ۳. signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 2 No 1 ☐ Yes Division of Vital Physician; 25. Was case referred to dical examiner? Be 26. Place of D th (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10k 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner 1 eath 1 Vatural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 2☐ Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 100

State Registrar 31. Date filed (Month, Day, Vear)

DHMH 17 Rev 1/2001

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** WILFOR aTheriNe /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Genesis-Catonsville Commons Catonsville Baltimore if Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 5, 1918 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2 X Yrs. 233-12-3578 91 Director Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1313 Kent Avenue 21207 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White ð 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Shaver Phoebe Shaver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) iit. Pages 1 and 2 so artment of Health ar sortant: If tem 27 is y Injury or other tra Thomas E. Scott / Nephew 1313 Kent Avenue, Baltimore, Maryland 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 Removal from State permit. Page Department c Important: If any Injury or once. Cedar Hill Cemetery Bonation 5 ☐ Other (Specify) 6/5/2010 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Corebras 'Medical Due to (or as a consequence of): xaminer Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): or Vital Records, P.O. Box 68760 attending physician IF FEMALE: 23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CV autopsy page performed certificate 1 Yes 2 No or Attending Physician; Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pendina investigation 2☐ Accident 1 ☐ Yes 2 ☐ No ours after death. 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled i 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) DA7683 3/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Miller 2835 Ave Soute Balmer MD Snith

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Year 2010 6:00 PM ne ISIAH WOODS, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Month, Day, Year | 03-24-1948 | 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Country) Director 215-46-8408 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director MD BALTIMORE 1 ¥ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a Examiner must be Funeral **5412 PURDUE AVENUE** 21239 USA 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Specify.BLACK 1 ☐ Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be flied within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **ENTRPRENUER** GRAPHIC DESIGNER Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည ISIAH WOODS, SR. ELIZABETH GLADNEY as Isiah Moods, Ji 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RHONA E. WOODS/WIFE 5412 PURDUE AVENUE, BALTO., MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State ST. STANISLAUS 6/9/2010 BALTIMORE, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician/ Due (or as a construence of) months Medica resulting in death) (or as a consquence of): Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) pate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Dav Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 Kio 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 은 1 PInpatient 2 PR/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

KNOWN

of death (Item 23a) (Type, Print)

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June June 2010 Anthony Waldrop 3:30 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 77 Ginwood Lane Essex Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🕱 M 2 🗆 F Months Hours Min. (Month, Day, Year) 04/08/1947 Director 461-70-8661 63 Usual Residence of Decedent show permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 77 Ginwood Lane 21221 U.S.A. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 X Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hydraulic Hose Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Waldrop Jean Reneaux 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darlene Waldrop / Wife 77 Ginwood Lane, Essex, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Anatomy Gifts Registry 06/03/2010 Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical UNG disease or condition resulting in death) Due to (or as a consequence of Examiner 30 YBARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for se a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? fo Month Day 4 Pregnant : 9 Unknown Year Pregnant at time of death 2 No the detached 9 Unknown Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: After this certificate has been signed by is completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by GBSTRUCTIVE LUNG 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a, Was an Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 034249 9010

Registrar
DHMH 17 Rev 7/2009

State

9649

32. Registrar's Signature

BRUTIMORB, MD-21236

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

· MO

CHRISTOPHER J ZATAC

31. Date filed (Month, Day, Year)

To the Hospital within 24 hours at To the Funeral C

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature that title of certifier

Ravi Passi,

15245 Shady Grove Rd.#130, Rockville, Md. 32. Registrar's Signatu

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

Trestifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D28656

29d. Date signed (Month, Day, Year)

5-12-2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar		State	of Maryl	and / Dep <i>Ce</i>	artmen			and M		giene	0 1 0		7636
		_	1. Decedent's Name	e (First, Middle, L	ast)							2. Date of Dea	ath Day	Yea		. Time of Death
	sicia: edica		INEZ ACI	KER				-				05/19/			1 -	0:50 A M
	mine		la. Facility Name (f			number)				Location of				County of De		
·*			Holy Cro	oss Hosp	ital	7 1-2 //-	to mit himble along	-	ver S	Sprine		9. Data of Pirt		ontgan		e (State or Foreign
Fune Direct	_	1	426-42-5		1□ M 21□ F	7. Age (iii)	yrs. last birthday, Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 03/22/	y, Year)	3. 0	Country)	MS
		t	Jsual Residence of									03/22/	1743			
arylan show	1	. 1	I0a. State	10b. County		1	. City, Town or L									Inside City Limits 1 ☐ Yes 2 🛣 No
ле Ма .8a-f :		000	MD	Montgom	ery		Silver S									
with th	i	בֿן בֿ	10e. Street and Nur		Correct			10f. Zip						zen of What (Country?	
eath		Funeral Director		now Mass		cedent Ever i	nIIS 13		0904	ispanic Ori	nin? (Sne	ecify Yes or No	USA	14. Race - Ar	merican I	Indian
fter d			 Marital Status 1 ☐ Never Marri 	ed 2 Married	Armed I 1 ☐ Yes	Forces? 2 📉 No	10.0.					ecify Yes or No- Rican, etc.)		Black, Wr		Transity .
5-0050 72 hours aft natural", or	100	5	3 🛚 Widowed	4 Divorced	If Yes, (Year or	Bive Dates:		1 ☐ Yes	2 A No	Specify:				Specify: B	lack	2
72 hc	TO SERVICE	Completed	(Spec	15. Decedent's E	Education rade completed	1)	(Give	dent's Usu kind of wo	rk done c	during mos	t of worki	ng i	16b. Ki	nd of Busines	ss/Indust	ry
within Han's		Ē	Elementary/Seco	ndary (0-12)	College	(1-4or 5+)		<i>DO NOT u</i> Stic V		′			н	ome		
Hygie of the right			17. Father's Name		st)		Donie	SCIC V	VOLICE		er's Name	(First, Middle,				
aty iditio Z i Z i 3-0030 should be filed within 72 hours after death with the Maryland and Mental Hygiene. In marked other than "natural", or items 23a or 28a-f show matic event the M-facel Eventher matter to mental the standard.		0 26	Herbert	Benjami	n					Geo:	rgia	Kelson				
			19a. Informant's Na	ame/Relationship	(Type. Print)		19b. Mail	ng Address	(Street	and Numbe	er or Rura	al Route Numbe	er, City o	r Town, State	e, Zip Co	de)
and 2 ealth a			Charles	Acker -	son		1510	4 Snow	v Mas	ss Co	urt,	Silver	Spr	ing, M	D 20)904
es 1	5	2	20a. Method of Disp	position □Cremation 3	□ Removal from	notata) 20	b. Place of Disp cemetery, cre	osition <i>(Nar</i> matory or o	ne of ther plac	e)	0	ate	20c. Lo	cation - City	or Town,	State
. Pages tment of tant: If its	'n			5 ☐ Other (Spec			acional				5/25,			go, MD		
permit. Pages Department of Important: If i	once		21. Signature of Fu	ineral Service Lice		wh	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	2. Name ar				nowden .				
			23 art 1. Enter the	he diseas or co	Continue that	coulond the	1					St, Roc		ie, ML	*	35U proximate
			shock, or hea	rt failure. List o	one cause or	each line		nei me moc	ie oi uyiii	ig, suci as	cardiac	or respiratory at	nest,		Int	erval Between set and Death
Physicia /Medic	_		disease or condition resulting in death)		a	eumolii	a sequence of):				_				-	
Examin	_						nal fai]	ure								
T) +		je l	Sequentially list cor if any, leading to im cause. Enter Unde	nditions, mediate	D		sequence of):									
ecute Ind transi		_	Cause (Disease or that initiated events resulting in death) I	iniury	C								-			
Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rid rietor; nade 2 should be detached for use as the burial-transit		Ш	resulting in death) t	Last	Due t	o (or as a con	sequence of):									
oor ificate g physi		dical			d											
ath certif			IF FEMALE: 23b. Was decedent	l prognant	23c. If yes, c	outcome of pre	egnancy							23d. Date of	delivery	
death atter		clar	in the past 12 1 ☐ Yes 2 ☐	months?		e birth 2□ I egnant at time		☐ Ectopic p ☐ Other (sp		У]	Month	Day	y Year
t the by the achee		nys	9 Unknown		9 □ Un	known										
es tha gned		5	Part II. Other signif			death but not	resulting in the	ınderlying c	ause give	en in Part I		23e. Did to	obacco ι	ise contribute	to the c	ause of death?
v requires to been signer should be			Rneumat	coid arth	aritis							1 🗆 1	Yes 2	□ No 3□	Probably	y 4X Unknown
law r law r las be		Сотріете										24a. Was autor	OSγ	prior	to compl	findings available etion of cause of
The The Cate Cate		5 _										perfo 1 □ Yes	rmed? 2 ZNo	death 1 🗆 Y	i? 'es 2[⊒No
VII.dli siclan: certifica rector. p		מ	25. Was case reference examiner?		Hospital:				Othe	or:		(Check only o				
Phys rathis		0	1 ☐ Yes 2 ☐ 27. Manner of Deatl		1 1	XInpatient : te of Injury	2 ER/Outpatie)A	4 L N		me 5 Resident			specify)	
Storm trending leath. tor: Afte			1X Natural 2 ☐ Accident	5 Pending investigation	(Mo	onth, Day, Yea		М	28c. Injur Work 1 □	k?¨` Yes 2 ☐		200. 2000		y 000aou		
Atter ar dea ector by the		ES	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	be 28e. Pla	ce of Injury - A	At home, farm, st	reet, factory	, office		-	28f. Location (Street an	d Number or	Rural R	oute Number,
tal or safte		Certification	4 Hornicide		Dul	lding, etc. (Sp	эеспу)				- 0	City or Tox	vn, State)		
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy Domoleely filled in by the funeral director, cade 2 should be detached for use as it			29a. Certifier (Check only one)	1 XCertifying F 2 Medical Ex	aminer: On the											
To the		Me	29b. Signature and	tle of certifier	()	11-		290	c. Licens	e number			29d. Da	te signed (Mo	onth, Day	v, Year)
0			1	ionsi	e XV	Mou	9	1	05669	91			5/1	9/10		
		1	30. Name and add	ess of person who	o completed ca	use of death	(Item 23a) (Type	Print)								
			Ghousia		12107	Herita	age Park	Circ	le,	Silve	er Sp	oring, 1	MD 2	0906		
Reg	State Jistra		31. Date filed (Mon	th, Day, Year) 21 201	0 Jens	Hegistrar's S	ignature face	المراي								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 55PM A isenber 2010 05 8 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner of Greater Washington FOCKVIILE Montgomer He brew Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. June 12, 1 7. Age (In yrs. last birthday 9. Birthplace (State of Social Security Number **Funeral** 1 X M 2□F 1915 Massachusetts 94 033-07-7964 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Rockville Maryland Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20852 United States 6121 Montrose Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 💢 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Salesman Grocery 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental I Important: If Item 27 is marked of any Injury or other traumatic eve once. Anna Rubenstein Meyer Aisenberg မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Aisenberg, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 05/24/10 1 Bunal 2 Cremation 3 Removal from State S. Florida Natl. VA Gemetery Lake Worth, FL 4 □ Donation 5 □ Other (Specify) of Funcial Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Acute /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Arting1 Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1∐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

To the Hospital
within 24 hours at
To the Funeral C

State Registrar

29b. Signature and title of certifier

21

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 montose Road, Rockirlle, mD · Chilakamars 31. Date filed (Month, Day, Year)

and manner stated

22. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month ca 14:13 trace a 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Viedica Center Anne Arunde nnapolis 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Month: none 1 D M 2 Director Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f shovedical Examiner must be notified at 10a State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 0 nited Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 ☐ Yes 1 Yes 2 ☐ No Specify: If Yes, Give Year or Dates Mexican Completed Specify: White 3 Divorced 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) none none is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Penarrieta ပ Melanie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2. Department of Health and Important: If item 27 is Martin/mother Road 322 elanie tine Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5/19/2010 George Wash.Cem. Adelphi, Md. 4 Donation 5 Other (Specify) PHILIP OD: RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Areme disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the hirial tran the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the at d be detached for Unknowr 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 24 hours after death.

Funeral Director: After this certificate has page 2 autopsy Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29b. Signature and title of certified Day, Year) 010 ss of person who completed cause of death (Item 23a) (Type, Print) Kwy Annapolis, Md 2/401 2001 Medical 31. Date filed (Month, Day, Yea 32. Registrar's Signature State 21 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MURRAY Month Day BURTON BLUME 2:35 \mathbf{P} M MAY 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Washington Adventist Hospital Takoma Park 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 79 Director 176-32-6789 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits 1 X Yes 2 No Montgomery Silver Spring ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral 28 Fleetwood Terrace S. 12. Was Decedent Ever in U.S. Armed Forces? 6/4/54

1X Yes 2 No If Yes, Give Year or Dates. 6/30/6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 Divorced 6/30/67 the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ne filed within 72 ntal Hygiene. ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Geotechnical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve P Joseph Blume Hilda Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Francine Blume--daughter 128 Fleetwood Terrace Silver Spring, Md 20910 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 5/18/2010 4 ☐ Donation 5 ☐ Other (Specify) National Crematory Falls Church, Va 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on e aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE MYOCARDIAL INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ORONARY ARTERY Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown o 🗌 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SCLERUSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, examiner? Hospital Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 2 No **Certificate:** 28d. Describe how injury occurred injury 1 Natural 5 Pendina 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Gentifying Nurse Practice or To the basis of my including open open occurred at the time. Job and place, and the cause(s) and manner stated. To the within 2 Gertifying Nurse Practiceer: To the best of my knowledge, doeth occurs 29b. Signature and title of certifier 300 Ru D40324 dress of person who completed cause of death (Item 23a) (Type, Print) JODRIE, MD, FACEP, 7600 CARROLL AVENUE, TAKOMA PARK, MARYLAND 31. Date filed (Month, Day, VAY 2

Registrar

Year)

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 21, 2010 Sarah Lou Baker 3:07 May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 6510 Paper Place Highland Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 7, 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** ^{Year)} 1918 Days Hours Months 1 □ M 2 □XF Mississippi 427-28-1318 91 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits in than "natural", or items 23a or 28a-f show the Medical Experiment must be notified at 1 X Yes 2 No Director Key Biscayne Florida Dade 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code U.S.A. 33149 268 West Mashta Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) U.S. Internal Revenue Elementary/Secondary (0-12) College (1-4or 5+) Service Secretary 12 should be filed w h and Mental Hygiei 7 is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Heath and Mental Important: If them 27 is marked c any injury or other traumatic eve Nora Flynt Thomas Chain ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20777 6510 Paper Place, Highland, Maryland Susan B. Gray - Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metropolitan Crematorium 5/22/10 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundral Service License 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home hovert 26401 Ridge Road, Damascus, Maryland 20872 X 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WELLES AUTE /Medical Due to (or as a consequence of Examiner URIMARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consecutable of Examine the death certificate be executed and Due to (or as a consequence of): burial-Box 68760, attending physician Physician/Medical as the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 □Yes 2 No P.O. the detached 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autopsy performed? page 2 The certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check nly one) 5 Residence 6 □ Other (Specify) Hospital: Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ this funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie May 21, 2010 D25947 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5540 Ten Oaks Road, Evelyn D. Jackson, M.D. Clarksville, Maryland 32. Registrar's Signature Year) State MAY Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May Day I3 Daneene E. Bowles 2010 2308 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F 214-13-6614 Hours 35 Sept^{th, 2}22^{Year} 1974 Maryland **Director** Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Me Leal Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 Hicks Ave 21401 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hyglene. Important! I item 27 is marked other than "natural", or items any injury or other traumatic event, the Me 1 Eal Examiner m. 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. þ Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Sales Clerk Kohl's Dept. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 DePaul Johnson Betty Ann Booth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Bowles (Husband) 5 Hicks Ave Annapolis, Md. 21401 20a. Method of Disposition 20b. PReof Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Memorial Park 5-20-10 Annapolis, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Minimame Rease of &cilisons Mortuary, 821 West St. Annapolis, Md. 13, Reese MOOY83 Jan 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Priysician/ ischemic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Indonying Cause (Disease or linjury Due to (or as a consequence of): the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day ed by the a detached f 1 Yes 2 L 9 Unknow a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No ☐ Yes the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🗘 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury Certificate: 28c. Injury at 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the 1 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tite of certifie 29d. Date signed (Month, Day, Year) 8510 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1

		1- For State Registrar			C	ertifica	ate of	Death					Reg. No				<i>-</i>
Physicia al Exami		Decedent's Name (First, N Kimyra Cha			2						ľ	2. Date of De Month May 12,	Day	Year		3. Time of Deat 2020 hrs	th
		4a. Facility Name (if not insti	ution, give	street and no			4t	c. City, Town		cation o	f Death	h 4c. County of Death					
Funeral		Prince George's Ho 5. Social Security Number	Spital C		7. Age (In yrs	lest birtt	nday)	Cheverly If Under 1		If Linde	r 24Hrs.	Prince George's 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or					<u> </u>
Director		216-81-891		M 2[X]F	2XF 2 Yrs. Months Days Hours Min.							Apri		Foreign Marv			and
ý		Usual Residence of Deceder 10a. State 10b. Cou			line C	h. Tour	or Locatio									10d. Inside City	u Limite
id how any Ee,		Md No. Cool	PC	2		nhai		"						1 X Yes 2			
filed within 72 hours after death with the Maryland I Hygiene. d other than "natural" or items 23a or 28a-f show, the Medical Examiner must be notified at once.	Director	10e. Street and Number		,				10f. Zip Coo	le				10g. Ci	tizen of Wh	at Count	ry?	
th the N 23a or 10tified		8433 Hamlin	Str					2070					JSA				
ath wit items ?	Funeral	11. Marital Status 1 X Never Married 2	Married	Armed F				Decedent of s, specify Cu				ecify Yes or N Rican, etc.)	10-	14. Race White		an Indian, Blac	ck,
한 등록	by Fu	3 Widowed 4	Divorced	1 Yes If Yes, Give Yes or Dates:	2 X No ar		1 🗌 🕻	Yes 2 🔀	No s	specify:				Specify:	в1	ack	
2 hours afte "natural", Examiner		15. Decedent's Education (ly highest gra				s Usual Occi					16b.	Kind of Bu	siness/In	dustry	
within 72 ene. er than " Medical	Completed	Elementary/Secondary (0-N/A	12)	College (1-4 or 5+)	N/	Α						N/	'A			
Hygien Other the M		17. Father's Name (First, Mic				12.7						(First, Middle	, Maide	n Surname)		-
permit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. In portant: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	To Be	Michael Bro		vne Print \		191	Mailing	Address (S				Jenni	_		n State	Zip Code)2 0	
2 shou h and h 27 is n imatic	ㅣ	Kiwana Jeni			her)							#102]					706
s l and f Healt If item er trau	Ī	20a. Method of Disposition 1 X Burial 2 Crema	tion 3	Removal fr		o. Place o	f Dispositi	ion (Name o				Date		. Location -			
Page ment o tant:]		4 Donation 5 Othe	Specify:		CI	aris	shir	rplace) nurch ce Ce	me		May	23.20°	10 1	3ermu	ıda		
permit. Depart Import injury		21. Signature of Funeral Ser Tyrone J.		/ -			22. Na	me and Add	ress of	f Facility	,	•				20011	1.50
nysician	1	23a. Part I. Enter the disease	or compi	ications that o	aused the de	ti. Do no	tenter the	one u	ing, su	YOU uch as c	ardiac or	respiratory a	enr errest, st	nock, or hea	SC.	NW Was	Interval
Medical kaminer		failure. List only one ca Immediate Cause (Final dise	ase a.	on line. Multiple Inj	juries	J	U									Between Ons Death	
		or condition resulting in deat	n) [Due to (or as a	a consequence	of):											
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca		Due to (or as a	a consequence	of):											
	Examiner	(Disease or injury that initiate events resulting in death) La	d -	Due to (or as a	a consequence	of):											
The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	ᆕᅜ		d														
te be ex tysiciar burial	Physician/Medica	UNPENDED IF FEMALE:		AMENDED	outcome of pr	oanana							12	2d Data of	ر حمد ناماد		
ertifica ding ph e as the	an/N	23b. Was decedent pregnant past 12 months?	n the	1 Live	birth	2	Feta	death	3	Ectopio	pregnar	псу	2	3d. Date of Month		ay Ye	ear
e atten	ysici	1 Yes 2 V No 9	Unknown	9 Unkn	nant at time of lown	death 5	Othe	er (Specify)	_				1				
d by th		Part II. Other significant co	ditions	contributing t	o death but no	t resulting	in the un	derlying cau	se give	en in Pa	ırt J.	23e. Did	tobacc	o use contr	ibute to t	he cause of dea	ath?
uires the n signe	ed by													✓ No 3			known
law req has bee 2 shou	Completed												is an opsy formedî	F		opsy findings a ompletion of car	
: The ificate r, page		25. Was case referred to me	Cont.									1 🗸 Yes			✓ Ye	s 2	No
ysician his cert directo	Be	examiner?		ospital: 1	Inpatient 2	✓ ER/O	utpatient				(Check o	Home 5	Resid	dence 6	Other:		
ing Ph After tl uneral	ت 1	27. Manner of Death		28a. Date		28b.	Time of Inj			at Work	?	28d. Describ	e how ir	njury occurr			_
l or Attendi after death. Director: d in by the f	톓		ending vestigatio	on		1936		1[s 2 🗸	No	Passenge			_		
al or A	Certification:		ould not be etermined	pe	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Major Road / Highway 28e. Location (Street and Number or Town, State) 1200 Brightseat Road, Landon										per, City		
Hospit 24 hour Funer tely fill		29a Certifier	Physicia		st of my knowl			ed at the time	e, date	and pla	1						
To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transpace.	Medical	one) 2 Medical	xaminer		of examination			on, in my opi	nion, d	death oc			te and p	lace, and c	due to the	cause(s)	
	Σ	29b. Signature and title of ce	tifier					29c. Lid	ense r					Date sign ay 14, 20		th, Day, Year)	
	- 1	1M1						. ()	LA IVI				1 1/12	9 V 144 /			
		30. Name and address of per	son who c	ompleted cau	ise of death (Ite	em 23a)											

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 15,2010 10:59p Eleanor Althea Bartlett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🖔 F Augnth 29, 1916 Confiecticut Director 048 07 7431 93 Usual Residence of Deceden r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Hyattsville MD ¶ Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 United States 2400 Griffen St Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Library Librarian permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Minnie Althea Buell George William Bartlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3615 Newark St., N.W. Washington DC 20016 Rudolf Bertrang /Friend Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
National Crematory 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Falls Church, VA 05/19/2010 4 Donation 5 Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Fune a Service Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SHOCK Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Use to (or as a consequence of): NEUMONIA attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last requires that the death certificate be exec Physician/Medical ARRYTHMIA CARDIAC as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Day Month Year Pregnant at time of death the P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY ORONARY 2 No 3 Probably 4 Unknown Records, Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an the Hospital or Attending Physician: The law autopsy performed this certificate 2 1No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\subseteq \text{Nursing Home} \) 5 \(\subseteq \text{Residence} \) 6 \(\subseteq \text{Other} \(\subseteq \text{Other} \(\subseteq \text{Specify} \) 1 🗌 Yes 2 W NO ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending (Month, Day, Year) within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 05/17/2010 29c, License number Frammy MID

State Registrar

DHMH 17 Rev 7/2009

WASHINGTON ADVENTIST HOSP, TAKOMA PARK, MD-20012.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SHAWN SHAMIM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death BRAMWELL Month Physician/ 5/1572010 12:32 p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Cheverly Prince George's If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Days Hours Min Jamaica, W. I. Months Director 83 218-57-1084 Usual Residence of Decedent or 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 Jamaica 503 Pacer Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 ☐ Yes 2 🔀 No 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", Specify. 3 Divorced 4 Divorced Completed **Black** 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Helper Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ಲ Unav. Caroline Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 Pacer Drive, Hyattsville, MD 20785 Wellesley Pitter / Son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗀 Removal from State permit. Page Department o Important: If any injury or 5/29/2010 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Cemetery Landover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Part 1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final herosalev Physician/ otre Cardiovascular disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ongesti-e attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 호 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has performed? 2 No 1 Ves 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) B Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 2 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death. To the Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0060100 AH was 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHMINA Silver

DHMH 17 Rev 7/2009

Registrar

Sest,

BLUD

32. Registrar's Signature

Universe

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year **EUGENNIA** L. MAY 20 2010 2:13PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HOLY CROSS HOSPITAL SILVER SPRING MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye AUG. 2, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Days WASHINGTON, DC 1962 Director Yrs 578-86-7271 47 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10h, County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗘 No MARYLAND PRINCE GEORGE'S NEW CARROLLTON 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a Examiner must b Funeral 5410 85TH AVENUE #202 20784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK 3 Widowed 4 XDivorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0~12) College (1-4 or 5+) ADMINISTRATOR ADMINISTRATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MILES BETHEA MABLE MCGREGOR-HOOD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MILES BETHEA - FATHER 6910 LAMP POST LANE, ALEXANDRIA, VA 22306 20a. Method of Disposition
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any Injury or ot Date 20c. Location - City or Town, State MT. COMFORT CEMETERY MAY 26, 2010 ALEXANDRIA, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility DEMAINE FUNERAL HOME Signature of Funeral Service Licenses Diana 520 S. WASHINGTON STREET, ALEXANDRIA, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ PULMONARY EMBOLISM disease or condition HOURS Medical resulting in death) Due to (or as a consequence of) Examiner LUNG CANCER MONTHS Sequentially list conditions if any acting to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Dun to for as a consequence of attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Month Day Year signed by the a 2 🔀 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performe 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🖾 No Hospital Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of I Director: After to 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifi 29d. Date signed (Month. Dav. Year) 059267 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LAWRENCE J. MARKOVITZ 2101 MEDICAL PARK DRIVE, SILVER SPRING, MD 20902

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 010 INA 0 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4h Cit Town, or Location of Death County of De 0 If Under 1 Year | HUnder 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** . Age (In yrs. last birthday) Months Days Hours Yrs Director Usual Residence of Decedent show County 10c. City, Town or Location r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** 10e. Street and Numb 10f. Zip Code 10g. Citizen of What Country? 21012 12. Was Decedent Eyer in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 2 If Yes, Give Year or Dates. Saltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. N/A Flementary/Seconday (0-12) College (1-4 or 5+) N/A N/A Be injury or other traumatic event, Department of Health and Mental His Important if Ifea 27 is marked oth any injury or other traumatter. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, p Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Durial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 6/1/2010 Glen Burnie. MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Ave. Annap Annapolis. MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): -transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month 1 Yes 2 No 9 Unknown onths? Day Pregnant at time of death n signed by the a lid be detached fo g Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2 🕅 No 3 □ Probably 4 □ Unknown completed filled in by the funeral director, page 2 should peen . Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed To the Hospital or Attending Physician; The lwithin 24 hours after death.

To the Funeral Director: After this certificate h 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Hospital 1 Yes Other: 2إ 1 Inpatient 2 ER/Outpatient 3 DQA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation M 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Yes 2 No

DHMH 17 Rev 7/2009

State Registrar

			1- For State of Maryland / Dep	ertificate of Death		.No.	7648
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
100	/Medic	al	JEAN LORINE BUIT 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	MAY	31 2010 4c. County of Death	8:26A M
	Examin	er	70 VILLAGE STREET	WALDORF		CHARLE	S
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) Coul	
	Director		404-14-8035 89 Yrs.		JAN.6,1	921 KE	NTUCKY
	irylanc show	_	10a. State 10b. County 10c. City, Town or L			1	10d. Inside City Limits
	he Ma 28a-f s	Director	MD CHARLES WALDOR	RF 10f. Zip Code	100	. Citizen of What Cou	1 ☐ Yes 2X No
	3a or	Dir	70 VILLAGE STREET	20602	109	U. S. A	-
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Americ Black, White,	can Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it. Its slich Exaction to the traumatic event, it. Its slich Exaction to the traumatic event.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Year or Dates:	1 ☐ Yes ♣☐No Specify:		Casaifu	HITE
21215-0036	72 hou natura iical	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	ina I	b. Kind of Business/In	
121	within sne.	mple	Flementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired) INISTRATIVE ASS		BRD. OF	EDUCATION
	filed (Hygid	Be Co	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma		<u> </u>
/lan	should be ind Mental marked c	To B	CLARENCE OLIVER NAUGLE	VALLI	E MAE FR	ITTS	
Maryland	2 sho h and is ma rauma			ling Address (Street and Number or Rui			
	1 and 2 Health lem 27 other tr			B LISA CIRCLE WA	Date 20	MARYLAND lc. Location - City or To	
<u>E</u>	Pages ient of nt: If ii		142 Buriai 2 Li Cremation 3 Li Removal from State	ematory or other place) JUI MEM.CEMETERY 7,	VE	IARKHAM,	(7.7)
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	22. Name and Address of Facility RA	MOND FU	NL.SERVI	CE,P.A.
	20 5 6 0		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	635 WASHINGTON	AVE., L	A PLATA,	MD 20646
	Physician		shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	ve Heast	- 1		
	Examiner	_	Sequentially list conditions, b. Congesti	ve Heart	Fael	leel	
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
oʻ	tificate be executed ig physician and as the burial-transit	Exa	that initiated events c. The sulting in death) Last Due to (or as a consequence of):				
68760,	ate be	Medical	d				
		/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy			20d Date of deliv	
P.O. Box	Physician: The law requires that the death cer this certificate has been signed by the attendin ral director, page 2 should be detached for use.	Physician/N	1 Live birth 2 Fetal death 3 1 Ves 2 MNo 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	Day Year
<u>Р</u>	at the 1 by the stache	hys	9 Unknown				
	w requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to t	
COL	w requ	letec			24a. Was an		opsy findings available
Be	The law ite has	Completed			autopsy performe	prior to co	ompletion of cause of
/ital	sician: The certificate h rector, page	BeC	25. Was case referred to medical examiner?		h (Check only one)	10103	2010
_	Physic rthis c		1 ☐ Yes 2 ☐ No		ome 5 Residence	ce 6 NOther (Speci	in ALF
on	nding Ph ith. : After th e funeral	tion	1-∄Natural 5 □ Pending (Month, Day, Year) Injury 2 □ Accident investigation		20d. Describe now	injury occurred	
Division of Vital Records,	Hospital or Attending 24 hours after death. Funeral Director: After itely filled in by the fune	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
Ω	To the Hospital of within 24 hours af To the Funeral D completely filled in		29a. Certifier 1- Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place	and due to the car	ice(s) and manner as	stated
	n 24 hos he Fun	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	red at the time, date	e and place, and due t	to the cause(s)
	To the vithing compared to the	ž	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	Day, Year)
			1 Killin	102831 2		6-7-10	>
			30. Name and address of person who completed cause of death (Item 23a) (Type	29 LePlat	a M	5 206	46
h	Sta Registr		31. Date filed (Month, Day, Year) 32. Begistrar's Signature	barke			
				Control of the Contro			

20 Th

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	aryland					Mental Hy	giene	2010	76	549
		ш	Registrar 1. Decedent's Name (First, Middle, Las	·†)		Cer	tificate o	ot Death)	_	Reg. No)		
	Physicia	ın/		,						2. Date of De	Da	y Year	3. Time of	f Death
	Medic Examin		Lorraine Virginia 4a. Facility Name (if not institution, give				4b. City. Toy	n, or Locatio	n of Death	May 20		10 . County of Dea	2:55	A
	Examin	ier	Holy Cross Hospit							l		•		
	Funeral		Social Security Number 6. Security Number	ex 7. Ag	e (In yrs. last	birthday)	If Under 1	Sprin ear IfUnd	er 24 Hrs.	8. Date of Bir	th	ontgomer 9. Bir	thplace (State of	or Foreign
	Director		216-64-0643	□м 2 🕅 F	87	Yrs.	Months D	ays Hours	Min.	Dec. 28	y Year)	922 Mar	yland	
	d t t	L	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	nation						10d. Inside Ci	it. Limita
	arylan a-f sh iied a	cto												s 2 No
	or 28% notif	Director	Maryland Montgome 10e. Street and Number	ry	Gaith	ersbu	10f, Zip Co	de		1	10a Cii	tizen of What Co		-
	with th		24414 Hipsley Mil	1 Dood			20882			1		iizen oi what o	ountry:	
	ems	Funeral	11. Marital Status	12. Was Decedent I	Ever in U.S.		Vas Decedent			ecify Yes or No-	<u>USA</u>	14. Race - Ame	erican Indian.	
ဖွ	or it	by F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀	No		f Yes, specify			Rican, etc.)		Black, Whit		
8	ural" ural"	ted	3 X Widowed 4 Divorced	If Yes, Give Year or Dates.		1	Yes 2 🛭	No Speci	fy:			Specify: W	hite	
21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	J.	(Give F	lent's Usual O kind of work de	one during me	ost of work	king	16b. K	ind of Business	Industry	
121	thin 7	[등	Elementary/Seconday (0-12)	College (1-4 or 5		life. DO	O NOT use ret	ired)				**		
d 2	filed within al Hygiene. d other tha vent, the I	ادہ ا	12 17. Father's Name (First, Middle, Last)			omema	ker	18 Mo	thar's Naa	ne (First, Middle,		Home	·	
an	uld be fill Mental narked o	힏	Fletcher Daniel B	annett						Lee Wrig		Surrierrie)		
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (T)		T.	19b Mailin	na Address (St			al Route Numbe		Town State Zi	n Code) 200	202
Ĕ	d 2 shalth and 127 is		Jane M. Wilkes, d	aughter						ıd, Gait				
Ē,	of Heal of Heal if item ?		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name o	f		Date		ocation - City or		
Baltimore,	permit. Page Department o Important: If any injury or once.		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		1		-		5/26	5/2010	Fred	lerick.	Marvlar	nd
alti	permit. Departn Importa any inju once.		21. Signature of Funeral Service Licens	ee						esworth				
<u> </u>	8 3 E E E		Han Wie	Due		26	401 Ri	dge Ro	ad, I)amascus	, Ma	ryland	20872	
н			23a. Pa 1. enter the disease, or comp shock, or heal failure. List only or	ne cause on each line	d the death. D	o not ente	er the mode of	dying, such a	as cardiac	or respiratory are	est,		Approximat Interval Bet	
-	Physician/		Immediate huse (inal disease or condition	a Metasta	atic E	ndome	trial	Carcin	ona				Onset and I	Death
	Medical Examiner		resulting in death)	Due to (or as								-		
		e.	Sequentially list conditions,	b. Due to (or as		aa afi:								
	ed ısit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or impury	Due to (or as	a consequent	ce oi).								
	xecut n and al-tra	Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequen	ce of):								
09	death certificate be executed ne attending physician and ed for use as the burial-transit	edical		d										
376		Med	IF FEMALE:											
ο̈́ ×	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	of pregnancy	v eath 3 □	Ectopic preg	nancy			1	23d. Date of de	-	
Box 687	death he ath ed fo	Physician/M	1 Ves 2 No	4 Pregnant a	t time of deat	th 5 🗆	Other (specif	y)				Month	Day	Year
P.O.	The law requires that the de ate has been signed by the a page 2 should be detached	Ph	Part II. Other significant conditions co	natributing to death b	ut not resultir	na in the w	nderlying caus	e given in Pa	rt I	220 Did to	basso	ise contribute to	the cause of d	loath?
σ,	es th signe I be d	Completed by	•	g			,g	- g				XINo 3□P		
g	requii	ete						·						
900	> 200	ᇤ								24a. Was autor		prior to death?	topsy findings a completion of c	ause of
Ä	n: The la ficate ha		25. Was case referred to medical							1 🗆 Yes	2 X No		s 2 No	
/ita	siciar certii irecto	m	evaminer?	Hospital:				6. Place of De	,					
of V	nding Physician: 1 tth. : After this certifica e funeral director, p	e: 10	27. Manner of Death	28a. Date of inju	ent 2 ER	b. Time of		4 [_] I Injury at	Nursing He	ome 5 Resid			cify)	
n C	nding ath. r; Afte e fun	icat	1 X Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day	y, Year)	injury		work? 1 ☐ Yes 2 [□No					
Division of Vital Records,	Atte er dez ectol by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju		, farm, stre	et, factory, off	ice				d Number or Ru	ral Route Numb	er,
Δ	tal or rrs aft al Dir led in	S		building, etc	. (Opecity)				- 1	City or Tow	n, State)			
	To the Hospital or Attending Physician: within 24 hours after deard. To the Funeral Director, After this certific completed filled in by the funeral director,	edical	29a. Certifier 1 X Certifying Phys (Check 2 Medical Exami	ician: To the best of ner: On the basis of e										nner stated.
	thin 2 thin 2 the I	Σ	only one) 3 Certifying Nurs 29b. Signature and title of certifier				eath occurred	at the time, da	ate and pla	ce, and due to the	e cause(s) and manner as	stated.	
	5 5 5 6 9			11000.00	10			ense number				e signed (Monti		
			30. Name and address of person who c	Nogus		a) (Tuno Pi	D692	288			May	20, 201	U	
	12		Yodit Neguesse, M	•	,	, , , , ,	,	Silva~	Spri	na Maz	w1 an	d 2091	0	
	Stat	e	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	2	have de		דוקט	us ral	x + G11	<u>u 2091</u>		
	Registra	r	何らて 2 1	-71HH - /2	Lacound .	100	BRICK							

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23a-d Per Phy G907 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month TERESA A. B. CALVIN 2010 May 1422 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Ray Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 □ M 2**X** F 141-28-0032 Septh, 128 Year 1931 Maryland 78 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 767 B Fairview Ave 21403 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3X Widowed 4 □ Divorced Black Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry
Anne Arundel Co. (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Educator Public School 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lawrence E. Blackstone Lovey L. Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Calvin(Daughter) 767 B Fairview Ave Annapolis, Md. 21403 20a. Method of Disposition 20b. Plade of Disposition (blane of cemetery, crematory or other) 20c. Location - City or Town, State Date 1 N Burial 2 Cremation 3 Removal from State Memorial Gardens 5-15-10 Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) Mmarne and assent Acility Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 sesa MOOY 83 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line. Myocardial Infarction Immediate Cause (Final Onsel and Death Physician/ disease or condition resulting in death) Medical Due to (4 as a consequence of):
Recurrent UTI Examiner Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated expenses or linjury) Examine Ovarian Cancer months nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes XX No 3 Probably 4 United own Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 No 1 Yes Yes • Hospital or Attending Physician: 24 hours after death.
• Funeral Director: After this certifical leted filled in by the funeral director, it 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Man of Death Certificate: 28a. Date of injury (Month, Day, Year) 28h Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of first knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. Certifying Nyrse Practionists To the best of my knowledge, death occurred at the time, date and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D66753 10 who completed cause of death (Item 23a) (Type, Print) Medical Parkway, Annayolis MD Turothy MAY 182010

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ Jane Elizabeth Cahill 18 11:05A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 9177 Bear Claw Court Owings Calvert Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. 11/19/1934 Washington. 578-44-1368 Director 75 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 👿 No Virginia Northumberland Heathsville 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 151 Circle Drive 22473 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced White 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) e 1 and 2 should be filed within 72 of Health and Mental Hygiene.
If item 27 is marked other than "r or other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) vears Branch Manager Banking Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Peter Spellbring Mary Ready 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer A. Pullins/ Daughter 9177 Bear Claw Court, Owings, Marvland 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lakemont Cemetery 5/21/10 Davidsonville, MD 21. Signatur of Seral Series 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CANCIER disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and -tran that initiated events resulting in death) Last Due to (or as a consequence of). attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed' death? certificate 1 🗌 Yes ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 4 ☐ Nursing Home 5 ☐ Residence 6 € Other (Specify) 10 Other: 1 🗌 Yes 2 XN0 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directions. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and fifte of certifier 2010 20811 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 BESTERTERO ANNAPOULS mp 21401 STANLEY 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAY 192010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month STEPHEN MATTHEW CONNARD 5.50 PM 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death OF HARYLAND MEDICA UNIVERSITY BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. July 15 New York 148-58-9475 50 **Director** 1959 Usual Residence of Decedent show 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits within 72 hours after death with the Maryland Director Anne Arundel Maryland Crofton 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1564 Eton Wav 21114 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1977-81 Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. U. S. House of Elementary/Seconday (0-12) College (1-4 or 5+) Auditor Representatives Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Robert Joseph Connard Madeline Patricia Touhy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian M. Connard/Wife 1564 Eton Way, Crofton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 5/19/2010 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home. 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final MYELDID LEUKEMIA Physician/ ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): SYYS Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) Cause (Disease or iinjury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death
Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1) HEART FAILURE To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate Yes 2 No 2 No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: Certificate: To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After 1 🛮 Natural 5 Pending work 1 Yes 2 No within 24 hours after death

To the Funeral Director: A
completed filled in by the fi Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Mamatt

State Registrar

6 * 1

31. Date filed (Month, Day, Year) MAY 192010 32. Régistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
22, South Greene Street, Baltimore, MD 21201

D0067839

2010

PRABHAKAR

AHTAMAM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ MAY 30,2010 3:05P RILEIGH GRACE CANLAS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CHARLES CIVISTA MEDICAL CENTER LA PLATA 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 X Months Days 1 1 2 - 2 2 - 2 0 0 8 218-83-3352 17MONTHSYrs. Director Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f MD. CHARLES LA PLATA 1 X Yes 2 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2002 BARLEY DRIVE 20646 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after 0 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic aurest. ģ 1 X Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)
infant College (1-4 or 5+) infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN HICKS CANLAS CAMI WEIMERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN H.CANLAS-FATHER 2002 BARLEY DR. LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State TRINITY MEM.GARDENS | 6-8-2010 4 Donation 5 Other (Specify) WALDORF, MD. 22. Name and Address of Facility
RAYMOND FUNERAL S
LA PLATA, MARYLAND Moo479 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death)) Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami that the death certificate be executed pato nding physician and use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Fetal deat in the past 12 months?
1 ☐ Yes 2 ★No Month Year filled in by the funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò To the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X N 2 No Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗌 No ဂ္ 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After t
completed filled in by the funera 1 Natural 5 Pending 1 🗌 Yes 2 🔲 No 2 Accident
3 Suicide Investigation Suicide 6. Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1114

manvan. MI

32. Registrar's Signaturé

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

DHMH 17 Rev 7/2009

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0022317

Daung D. S. P. C. BOX 940

29d. Date signed (Month, Day, Year)

06 [01/10

SILPASUVAN, MD 0 1430 Solomons Huntingtons

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month | Year COOPER **Physician** CLARK 10 A M DEAN 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner FREDERICK 123 51 FRODERICK WEST SOUTH If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 3 Will 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 17 M 2 □ F Months Hours Director TRE 10, 1945 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County 28a-f show traumatic event, the Medical Evaminer must be notified at 1 Yes 2 No MD FREDORIUR Frootrick Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or ; WEST 500TH ST 12 21701 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify ģ Specify: WHITE 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) DISABLED 12 TH GR is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be HERBURT DOPER WISNOR STELLE ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SISTRA) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau BROWN LANG Knowing MD 21759 PATRICIA KISNOR OHN 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SMITH BURG CREM APR 16,2010 SMITIBBURG 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility GARY L. ROLLINS FUN. muy d. 110 WEST SOUTH ST FREDERICK MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause or each line. Immediate Cause (Final Physician Mariar CN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has al director, page 2 s autopsy performed? Yes 22 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation s after death.

I Director: A in by the fu 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours af

To the Funeral Di

completely filled in 🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

32. Registrar's Signature

Brisana

DR. WILLIAMH. CAZIREY MD

DHMH 17 Rev 1/2001

TIOMA

29d. Date signed (Month, Day, Year)

MO

JOHNSON DR FRED Give

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 13, 2010 Year DEAL **GEORGE** 12:19 RM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S GENERAL HOSPITAL PRINCE GEORGE CHEVERLY Social Security Number Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F Months Days Hours (Month, Day Director 578-52-8739 68 9-8-1941 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director PRINCE GEORGE'S MD CAPITOL HEIGHTS Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 907 ABEL AVENUE 20743 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force 1 Never Married 2 Married Black, White, etc. þ ☐ Yes 2 🛛 No Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Specify: BLACK Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10TH GRADE HEAVY DUTY EQUIP. OPERATOR WSSC permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **JAMES** DEAL BEATRICE LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH C. DEAL--WIFE 907 ABEL AVE. CAPITOL HEIGHTS, MD 20743 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) INCOLN MEMO. CEM. 5-24-10 SUITLAND, MD 22. Name and Address of Facility PINCKNEY-SPANGLER F. H. 524 - 8TH ST., N. E. WASH., DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. ot enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Physician/ CARDIOMYAPOTH disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician by Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIABETUS MELITUS Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 Ho 욘 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation upleted filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Rate Fin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Box 68760

P.O.

Records,

of Vital

Division

ROINTAN FARAMIFAR, M.D. 12150 ANNAPOLIS ROAD GLENN DALE, MD 20769

32. Registrar's Signature

D 43446

5-13-2010

	1	For State Registrar			d / Depa		Health and	Mental Hy	giene Reg. No.	10	17656			
Physician /Medical	L		Diabagat					2. Date of De Month 4/3	0/20		3. Time of Death 5:45 P			
Examiner	4	4a. Facility Name (If not institution, gi				4b. City, Town,	or Location of Deat	th	4c. C	County of Death	n			
Funeral Director		1726 E. Lafa 5. Social Security Number 6. 225-25-3004	Sex 7. A		ast birthday) Yrs.	If Under 1 Year Months Days	altimor If Under 24 Hrs Hours Min.	8. Date of Bin (Month, Da	th y, Year) /1951	Tyzol	nplace (State or Foreigntry) ry Coast			
P .		Usual Residence of Decedent						3/12/	1951	0				
anylar ehow		10a. State 10b. County Md.		1	, Town or Lo ltimo						10d. Inside City Limi 1 ☑ Yes 2 ☐ N			
riter death with the Mar ritems 23s or 28e-fel niter crist be notified. Funeral Director	-	10e. Street and Number	ette Ave	1		10f. Zip Code 212	1 3		-	en of What Co	•			
		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Drivorced	12. Was Decedent Armed Forces' 1 Tyes 2 M If Yes, Give Year or Dates:	?	1		Hispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)		4. Race - Amer Black, White Specify: B				
72 ho		15. Decedent's 8 (Specify only highest gi	ducation		16a. Deced	lent's Usual Occur	pation during most of wo	ndrina	16b. Kind	d of Business/I	ndustry			
30	-	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	CPA	during most of wo	rang	Acc	ounti	nq			
Hygie Hygie ather i ant, in		17. Father's Name (First, Middle, Las	5+				18. Mother's Na	me (First, Middle,						
Mental H Mental H arked ott attc even		Sotidui Diaba	gate				Amina		atta					
shou and M s mar umat		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or Ru		r, City or	Town, State, Z	ip Code)			
and 2 palth a n 27 li er tre		Adama Diabaga	te/broth		6011	39th A	ve. Hya	ttsvill	le, I	Md.207	82			
of He of He r oth	12	20a. Method of Disposition ↑ Burial 2 □ Cremation 3 [Removal from State	20b. Pl	lace of Dispo emetery, cren	sition (Name of natory or other pla	ce)	Date		ation - City or				
Pag ment ent: f ury o				Al	Fird	aus Cen	net. 5-	-9-10	Fre	deric	k,Md.			
permit. Pages 1 and 2 should be tiled within Department of Health and Mental Hygiene. Importent: If tlem 27 is marked other than any injury or other treumatic event, It a Magnes. To Be Compl		21. Signature of Funeral Service (A)	Al Firdaus Cemet. 5-9-10 Frederic Signature of Funeral Service (Appsee 22. Name and Address of Facility Universal Mortu 411 Kennedy St NW Washington, D											
		23a. Part1. Enter the dise set, or con shock, or heart failure. List only	Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
hysician /Medical		Immediate Cause (Final disease or condition resulting in death)		tast	atic	lung	2	arano			Onset and Death			
Examiner e		Sequentially list conditions, if any, leading to immediate cause. Enter or Jorlying Cause (Disease or injury that initiated events	b. — Due to (or as	a consequ	uence of):									
te be executed ysician and e burial-transit cal Examiner		Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequ	uence of);									
r this certificate has been signed by the attending physical director, page 2 should be detached for use as the To Be Completed by Physician/Medic.		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗆 Fetal	death 3	Ectopic pregnanc	у		23	3d. Date of deli Month	very Day Year			
signed to detail		Part II. Other significant conditions HIV	contributing to death t	out not resu	ilting in the ur	nderlying cause gr	ven in Part I.		obacco us res 2 🗆		the cause of death?			
cate has been si page 2 should I	ı	Hepalitis	В					24a. Was	an	24b. Were au	topsy findings availab			
certificate has rector, page 2	•							autor	rmed?	prior to death?	ompletion of cause o			
ertitical actor, p		25. Was case referred to medical		·			26. Place of Dec	1 ☐ Yes ath (Check only o	2 (No	1 ☐ Yes	3¢ No			
nysici his cer I direct		examiner? 1y∑ Yes 2 ☐ No	Hospital: 1 Inpati	ent 2 🗆 E	ER/Outpatien	t 3 DOA	ner: 4 \(\text{Nursing } \)	The same of the sa		□Other (Spec	eifv)			
ath. Tr. Atter this certificate his tuneral director, page tuneral control of tuneral director, page atlon; To Be Com		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation		ury uy Year)	28b. Time of Injury	28c. Inju Wo	ry at rk? Yes 2 □ No	28d. Describe						
To the rospinal or Attending Vithin 24 hours after death. To the Funeral Director: Attent completely filled in by the tuners Medical Certification;		3 Suicide 6 Could not l 4 Homicide determined	280. Place of in	jury - At ho tc. <i>(Specify</i>	me, farm, str	eet, factory, office		28f. Location (: City or Tox	Street and vn, State)	Number or Ru	ral Route Number,			
in othe hospital or Attending within 24 hours after death. To the Funeral Director: Alter completely filled in by the tune Medical Certification		29a. Certifier (Check only one) Certifying P	hysicien: To the best miner: On the basis of and manner st	of examinat	wledge, death ion and/or inv	occurred at the ti restigation, in my	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)			
S T S S S S S S S S S S S S S S S S S S	1	29b. Signature and title of certifier	HOW	MAN	BMBCh D	29c. Licens	T9136			signed (Month	, Day, Year)			
Q	1	30. Name and address of person who	WRIGAN, D	FRT	OF ON		1, JOH	NS HO			IOSPITAL			
State Registrar		31. Date filed (Month, Day Year)	32. Reg	rar's Signat	the s									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Arundel</u> Anne Arundel Medical Center <u>Anne</u> Annapolis Birthpic Country) NJ . Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 096-12-0943 88 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes XX No MD Anne Arundel Annapolis 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral with 1000 Mastline Dr. 21401 USA hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

**EXX Yes 2 \sum No 1942-Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: 3 Widowed 4 ☐ Divorced Specify. 1946 Completed th and Mental Hygiene. 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working within 72 life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Paralegal Insurance/ Law Manager/ Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ည Herbert William Dahlman permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic once. Harriet Theresa Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffrey Stuart Dahlman (nephew) Hobart Ave, Short Hills, NJ 07078 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 7/28/2010 Arlington National Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sen ice Uit ensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 1 Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Mon MUS Immediate Cause (Final TEAK Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a sone squaree of k or Attending Physician: The law requires that the death certificate be executed ig physician and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Records, P.O. Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Year Pregnant at time of death 5 Other (specify) Day been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🕼 o 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy perform 1 Yes 2 No r. After this certifica **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes 1 Enpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending ours after death.

neral Director: Aft
filled in by the fur 1 Yes 2 No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Fune

completed file 29a. Certifier 3 🗋 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certifier completed cause of death (Item 23a E69

State

Registrar

182010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 19, Year Joseph Emmet Dowling 2010 3:27 PM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 8, Date of Birth Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days 1 **X** M 2 □ F Months Hours Aug. 1925 District of Columbia 84 579-32-6998 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Silver Spring Montgomery Maryland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20904 USA 3114 Gracefield Road, #106 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 2 🗌 No 1 ☐ Yes 2 No Specify: If Yes. Give Specify: White Year or Dates. WWII 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Federal Bureau of Elementary/Seconday (0-12) College (1-4 or 5+) Investigation Special Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Cecilia Clark Emmet J. Dowling 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3114 Gracefield Road, #106 Silver Spring, MD 20904 Dolores Theresa Dowling Wife 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2/12 Cremat 3 Rem n State May 24, 2010 Silver Spring, MD 5 Nother (Specify En Combinent Gate of Heaven Cemetery 4 Donation 22.Name and Address of Facility Francis J. Collins Funeral Home, 500 University Blvd., W., Silver Spring, Inc. MD 20904 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year Pregnant at time of death Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown

Pnysician/ Medical Examiner Examiner

Physician/

Medical

Director

Funeral

ģ

Completed

Be

ည

Examiner

Funeral

Director

show

"natural", or items 23a or 28a-f s edical Examiner must be notified

event, the Medical

and Mental Hygiene.

is marked other than

within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

burial-transit and physician the burial attending pl signed by the a d be detached f page 2 has certificate ! : After this certification and funeral director, I this

Physician/Medical Completed by Be ည Certificate:

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed To the Hospital or Attendin within 24 hours after death.
To the Funeral Director; Aft completed filled in by the fur Medical 20+1

> State Registrar

resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure Were autopsy findings available prior to completion of cause of 24a. Was an Arterial Fibrillation autopsy death? 1 Yes 2 K No 1 Yes 2 XNC 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2X No 1 Tyes 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 XNatural 5 Pending 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) City or Town, State) 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

D66249

MD 1500 Forest Glen Road, Silver Spring, MD 20910

May 20, 2010

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Duran,

Jonathan M. 31. Date filed (Month, Day, Year)

MAY 21 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>010</u> Physician/ Month May 13 Franklin Spencer Davis 9:04 pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 D F Days Months MOT 1991 1937 **Director** 578-54-1483 72 Hawaii Usual Residence of Decedent or 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location **Funeral Director** traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 N No Maruland Montgomery Colesville 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 531 Randolph Road 20904 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify. If Yes, Give 3 Widowed 4 X Divorced Specify: Caucasian Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Driver Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Spencer Edward Davis Rachel Elizabeth Hopper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maximillian Davis - Son 15136 Fairlawn Avenue, Silver Spring, Maryland20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 permit. Page 1 Department of Important; If it any injury or o 1 Burial 2 D Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Crematory 05/21/2010 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 1232 | 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 MONTHS Immediate Cause (Final Physician/ Metastatic Sarcoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? To Be Completed by within 24 hours after death...y rivstruatr; the law require.

To the Funeral Director: After this certificate has been significant of the funeral director, page 2 should the funeral director. 1 \square Yes 2 X No 3 \square Probably 4 \square Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 🔀 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛛 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 X DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 \square Pending Accident Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examples: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contrigue Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only/on and title မ D67258 May 17, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicholas Farrell, MD, 9707 Medical Center Drive, Rockville, Maryland 20850

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 Janie B. Douglas 2010 <u>9:3</u>0 ^aм Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death <u>Prince George's</u> 1000 Chillum Road <u>Hyattsville</u> 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min (Month, Day, Year, Country) South Carolina Director 249-01-6470 91 /1/1919 Usual Residence of Decedent shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits rector 1X Yes 2 ☐ No MDPrince George's Hyattsville 듑 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1000 Chillum Road 20782 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Completed Black Year or Dates. 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Worker ye 1 and 2 should be filed wit t of Health and Mental Hygie If item 27 is marked other i Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mack Davis Janie Longshore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Chillum Road Hyattsville, MD 20782 Loretta Rotan - Daughter Baltimore, Department of He. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 1 🖰 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 5/28/2010 Brentwood, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. Bladensburg Road Brentwood, MD 20722 23a. Part UEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Congestive Heart Failure months Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation months Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury Exam that the death certificate be executed 5 Months <u>Cerebrovascular Accident</u> and that initiated events resulting in death) Last Due to (or as a consequence of) burial attending physician for use as the buria Physician/Medical Hypertension Many years Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Pregnant at time of death 5 Other (specify) the 9 Unknown g 🗌 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, Renal Insufficiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Clostridium Difficile Colitis The law has autopsy performed? death? certificate 2 No Yes 2 X No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA this n 24 hours atter useum. he Euneral Director: After th moleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Hospital Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the comple 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) no completed cause of death (Item 23a) (Type, Print) 30. Name and address of person w 20782 Tesfaye Hyattsville, MD Gaby Testaye.

1. Date filed (Month, Day, Year) 6525_Belcrest_Rd

DHMH 17 Rev 7/2009

Registrar

MAY 2 5 2010

32. Registrar's Signature

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month John Gregory Dawson 0850 Medical 4a. Facility Name (if not institution, give street and number)
Western MD HealthService **Examiner** 4b. City, Town, or Location of Death 4c. Counfy of Death Cumberlana Allegany 7. Age (In yrs. last birthday) 62 yrs. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec. 24 Year 1947 Hours 232-74-4598 Kevser, WV Director Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director WV Mineral Keyser 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a P.O. Box 585 with 26726 USA items within 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ò ģ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", 3 Divorced 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Counselor State of WV Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wilbur P. Dawson Louise Evelyn Fink 19a. Informant's Name/Relationship (Type, Print)
Deborah Dawson/wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
P.O. Box 585, Keyser, WV 26726 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Potomac Memorial Date 20c. Location - City or Town, State 6/03/2010 4 ☐ Donation 5 ☐ Other (Specify) Keyser, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Markood - Funeral - Home, P.O. Box 912, Keyser, Ine. Mar Wv 26726 Markwood Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Hetanap Sequentially list conditions. sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

24 hours after death.

25 hours After this certificate has been signed by the attending physician and ared filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 T Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 2 No 1 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 \(\sum \) Yes 2 \(\sum \) No iniury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours aff To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0069627 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12501 WILLOW Brook Ro. Cumberlan arapura py 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 1^{Day} June 2010 Robert Joseph Dvorak, Sr. 1421 РΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton Union Hospital Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral NOV 4, 1933 1 🕅 M 2 🗆 F Maryland Director 215-32-6665 76 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 2540 Singerly Road United States 12. Was Decedent Ever in U.S. Armed Forces? 1/21/54
1 M Yes 2 No to
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Year or Dates 12/23/55 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph E. Dvorak Marie A. Smrcina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Richard P. Dvorak/Son 2556 Singerly Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June 5 Immaculate 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Cherry Hill, MD Cemetery ture of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Porco disease or condition Medical resulting in death) Examiner Examiner attending physician and for use as the burial-transit Physician/Medical Division of Vital Records, P.O. Box 68760 Completed by

or Attending Physician; The I

To the Hospital or Attendion within 24 hours after death. To the Funeral Director At

Examir	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c			
ian/Medical		d			
nysician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of de Month	elivery Day Year
Completed by Physic		contributing to death but not resulting in the underlying of	cause given in Part I.	, , , , , , , , , , , , , , , , , , ,	Probably 4 🗆 Unknown
Comple				autopsy pnor to performed? death?	utopsy findings available completion of cause of
Be (25. Was case referred to medical		26. Place of Death (Chec	ck only one)	
전 E	examiner? 1 Yes 2 No	Hospital:	OA Other: 4 Nursing H	ome 5 Residence 6 Other (Spe	ecify)
Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigatio	(Month, Day, Year) injury M	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred	
Certi	3 Suicide 6 Could not to 4 Homicide determined	e 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)	y, office	28f. Location (Street and Number or Ri City or Town, State)	ural Route Number,

1 X certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P0055190

Uylon Hospital 06 Bow Street Elkfon MB 2182/

State Registrar

Medical

29a. Certifier

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

THIN .

alpa af some

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Capies Are Legible.
Amend Item 2 per phys. G904 6/710 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 2010 3. Time of Death Physician/ 04:29AM Joshua Allyn Forsythe MA 2009 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Sinai Hospital Baltimore City If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 19) 9. Birthplace (State or Foreign Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** ^{Year)} 1994 Marvland 217-41-5713 16 Director Doshus A. Forsthe Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 XYes 2 No Maryland Washington Hagerstown 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number Funeral 934 Marion Street 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Student High School 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stept Known as ည Scott Andrew Crist Ann Maria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 934 Marion Street, Hagerstown, Maryland 21740 Mother Ann M. Forsythe-Crist 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 05-27-10 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee

Recommendation Andrew K. Coffman Funeral Home, Inc. 40 East Antietam Street, Hagerstown, 21740 Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician, neu monia disease or condition resulting in death) Medical Due-to (or as a consequence of) Examiner mouth Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Q is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 🔼 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 HNO 1 Inpatient 2 ER/Outpatient 3 DOA ျ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury (Month, Day, Year) Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto MD 21215 Belvedere M M Joseph 31, Date filed (Month, Day, Year) State May 01 Registrar

Di

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. Amend 25 per phys. 6904 6/17/10 dk State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 2010 Ena E. tom Felde 3:35 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1308 Roosevelt Street Annapolis Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 578-50-9466 1 □ M 2 屎 F 5/10/1908 102 Germany Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1308 Roosevelt Street 21403 USA Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ¥ No Specify: Specify: White 3 Nidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Friedrick von Mickwitz Emilge von Mickwitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1308 Roosevelt St, Annapolis, MD 21403 Olaf tom Felde - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Baltimore Crematory 5/13/2010 Baltimore, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home 21. Signature of Funeral Service Licenses Muglin T. Klobert 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Urosepsis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 🗌 Yes 24 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 1 Residence 6 ☐ Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner eath 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 🔄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) gistrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Majy Physician/ 17 6:49 Carlos Francisco Fernos Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 1 ፟፟፟ M 2 ☐ F 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min (Month, Day, Yea Director 55 583-88-9811 May New Usual Residence of Decedent ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event in ury ev 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Montgomery Damascus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20872 12025 Bethesda Church Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ Specify: White 1 ☐ Yes 2 X No Specify: Year or Dates. 1977-93 Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Library Elementary/Seconday (0-12) College (1-4 or 5+) of Medicine Librarian Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Sheila Celly Capo Carlos | Manuel Fernos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bethesda Church Road, Damascus, Maryland 2087 Ihsia Hu, wife 12025 Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date M Burial 2 Cremation 3 - Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) All Souls Cemetery 5/25/2010 Germantown, Maryland 21. Sign, ture of F 22. Name and Address of Facility Molesworth-William Funeral Home 26401 Ridge Road, Damascus, Maryland 23a. Part 1 ner the disease, or complications that valued the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shocl, or leart failure. List only one cause on each line. Interval Between Immediati Cau e (Final disease o condition resulting in th) Onset and Death Physician/ Medical Examiner Sequentially list conditions, if the leading to in including cause. Enter Underlying Cause (Disease or linjury that initiated events Examine burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown be detached 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page 1 Yes Yes 25. Was case referred to medical completed filled in by the funeral director Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural s after death. 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 MOD 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hee Nam 7th St Frederick, MD 21701 400 Myuna 1941UA 31. Date filed (Month, Day Y 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		irtment of He <i>tificate of De</i>			iene	0	7667	
			Decedent's Name (First, Middle, Last)					2. Date of Deatl	h	.,	3. Time of Death	1
	Physicia Medic		CATHERINE	Ε.	F	ORD		Month MAY	12 2	Year 010	1:54 P ^M	
	Examin		4a. Facility Name (if not institution, give stree	et and number) MANDR	ΪÄ	4b. City, Town, or L	ocation of Death		4c. County	of Death		1
.1			3675 SOLOMONS ISLA	ND ROAD		HARWO			ANNE			
	Funeral		5. Social Security Number 6. Sex 1 □ N	7. Age (In yrs. last	t birthday) Yrs.		Hours Min.	8. Date of Birth (Month, Day,	Year)	Countr	ace (State or Foreign	
	Director		578-52-6481 Usual Residence of Decedent	88	113.			OCT. 11	1921	WASH	INGTON, DC	+
	land show d at	o	10a. State 10b. County	10c. City,	Town or Loc	cation				10	d. Inside City Limits	٦
	Maryli 8a-f tifiec	rect	DC	W	ASHING	TON					1 🛚 Yes 2 🗆 No	
	the land or 2 se no	۵	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Count	ry?	1
	s 23a	Funeral Director	1304 FRANKLIN STRE	EET N.E.			20017		USA			
	death item		Tr. Maritar Otatas	Was Decedent Ever in U.S. Armed Forces?		Vas Decedent of Hisp Yes, specify Cuban,				- America		
36	after I", or xamil	d by	1 Never Married 2 Married	1 ☐ Yes 2 🗓No If Yes, Give	1	☐ Yes 2 🗓 No	Specify:			BLACK		
21215-0036	ours atura cal E	Completed	3 Widowed 4 ☐ Divorced 15, Decedent's Educa	Year or Dates.	16a Deced	ent's Usual Occupati	ion		16b. Kind of Bu			
15	an "n Medi	mpl	(Specify only highest grade of Elementary/Seconday (0-12)	ompleted)	(Give k	kind of work done dui O NOT use retired)		ing	TOD. KING OF BU	siress mu	ustry	1
212	withir giene er tha		12TH	College (1-4 or 5+)	OF	FICE SUPER	RVISOR		GOVERN	MENT		
bu	filed all Hyger of other svent	Be (17. Father's Name (First, Middle, Last)					e (First, Middle, M	laiden Surname)			
yla	ld be Ment arker atic e	욘	WALTER PERKINS				LUCY L	ANSDOWNE				_
lar	shou and is m		19a. Informant's Name/Relationship (Type,	· ·		g Address (Street an			-			
e)	and 2 Health		DAWN DALTON/GRANDI 20a. Method of Disposition			MANDARIN						4
Baltimore, Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 🙀 Cremation 3 ☐ Ren	noval from State cer	netery, crem	sition (Name of natory or other place)			20c. Location -			
Iŧir	iit. Pa irtmei irtani injury		4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Serule Licensee	RIV		E CREMATOR		7/2010 J.B. JEN	RIVERDA			-
Ba	permi Depar Impo any ir		2 Signature of Linetal Serve Licensee	-		Name and Address AAAA LANDO						
			23a. Part 1. Enter the disease, or complica								Approximate	1
	Pnysician/		shock, or heart failure. List only one commediate Cause (Final	ause on each line.							Interval Between Onset and Death	١
	Medical		disease or condition resulting in death)	CANCER-UNKN Due to (or as a consequent	OWN P	RIMARY				-	weeks	+
	Examiner		Cognostially list conditions									
	_ +	Examiner	Sequentially list conditions, if any, leading to immediate couse Enter Underlying	Due to (or as a conseque	nce of):							
	cuted	xarr	Cause (Disease or iinjury that initiated events c.	Due to fee as a series						-		_
	cate be executed physician and the burial-transit	alE	resulting in death) Last	Due to (or as a conseque	nce oi):							
Box 68760	physi the b	edical	d							\pm		-
89	sertific nding ise as	n/M	IF FEMALE: 23b. Was decedent pregnant 23c.	If yes, outcome of pregnand					23d Date	e of deliver	rv	
XO	eath c atter	icia	in the past 12 months? 1 ☐ Yes 2 █ No	1 Live Birth 2 Fetal of 4 Pregnant at time of de		Ectopic pregnancy Other (specify)			Mor		Day Year	
Э. В	the di by the ached	Physician/M	9 Unknown	9 Unknown								_
P.	s that gned t	by F	Part II. Other significant conditions contri	outing to death but not result	ting in the u	nderlying cause give	n in Part I.				e cause of death?	
ds,	quire en sig buld b	ted						1 □ Ye	es 2 🛭 No	3 🗌 Prob	ably 4 Unknown	
COL	aw re las be	Completed						24a. Was ar autops	у р	rior to con	sy findings available npletion of cause of	
\mathbb{R}^{e}	The l	Con						1 Yes 2		eath?	2 X No	
tal	ician: certific ector,	Be	25. Was case referred to medical examiner?	oital:		26. Plac	e of Death (Check	k only one)		MA	NDRTN	j
<u>\</u>	Phys this ral dir	<u>۲</u>	1 Yes 2 No	1 ∐ Inpatient 2 ∐ E	R/Outpatien 8b. Time of	t 3 DOA 28c. Injury a	4 ☐ Nursing Ho	ome 5 Reside 28d. Describe ho			ANDRIN HOUSE	_
טע	ding th. After fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work?	es 2 🗆 No	20d. Describe no	w injury occurre	u		
isio	Atter	Certificate:	3 Suicide 6 Could not be	28e. Place of Injury - At hom	e, farm, stre	et, factory, office		28f. Location (Str		r or Rural I	Route Number,	1
Division of Vital Records, P.O.	tal or rs after al Dir			building, etc. (Specify)				City or Town	, State)			
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical		n: To the best of my knowled On the basis of examination a								
	thin 2 the I	Me		actioner: To the best of my k		leath occurred at the t	time, date and place	e, and due to the	cause(s) and mai	nner as sta	ted.	_
	5.≱ 6 8		255. Signature and the or certifier	(000001	1111	29c. License r		25	9d. Date signed			
	24		30. Name and address of person who comp	relack 1	(Tuno 17	D4483	<u>ა</u> გ		MAY	13, 2	2010	_
	17			M.D. 445 DEF	ENSE		NNAPOLIS	, MARYLA	ND 2104	1		
	Sta	e	31. Date filed (Month, Day, Year) NAY 2 0 2010	32. Regis ar's Sig atu							<u> </u>	
	Registra	ar	MAT S A ZUIU (Mass	CANNON MY								1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	State of Maryland / Department of Health and State of Maryland / Department of Health and Certificate of Death		giene Reg. No.	7668
	0		1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Ellie Toni France	May 15,		09:08a ^M
7	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deal	th	4c. County of	Deeth
			10800 Indian Head Highway #G25 Fort Washingto			George
ı	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min	(Month, Day		Birthplace (State or Foreign Country)
E	Director		128-30-1984	10-24-1	.939 S	outh Carolina
and	*		Usuel Residence of Decedent 10a, State 10b, County 10c. City, Town or Location			10d. Inside City Limits
Aaryl	show	ō	MD Prince George Fort Washington			1 X Yes 2 □ No
the	28a-	Director	10e, Street and Number 10f. Zip Code		10g. Citizen of Wha	at Country?
with	Na or		10800 Indian Head Highway #G25 20744		U.S.A.	
death	ms 2	Funerai	11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (5	Specify Yes or No-		American Indian,
after o	or Ite		1 Never Married 2 Married 1 Tyes 2 Married 1 Tyes 2 No	to rican, etc.)		White, etc.
3 sun	el'. o	by	Wildowed 4 □ Divorced If Yes, Give Year or Dates:		Specify:	lack
LICE 12.0000 be filed within 72 hours after death with the Maryland	"natural", or items 23a or 28a-f olical Exeminet must be modifie	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	orking	16b. Kind of Busin	ness/Industry
E L	Max Max	npldu	Elementary/Secondary (0-12) College (1-4or 5+)	-	Self-En	nloved
M 98	ygier t.	Co	1201	ma /First Middle	Maiden Surname)	iptoyed
9	d off	Be	A Table of table of the control of t		Malderi Surname)	
should be filed within	Freath and Mental Hygiene them 23s or 28s-1 show them 27 is marked other than "natural", or thems 23s or 28s-1 show other traumatic event, the Modical Exertine must be rudified at	2	Alexander McGuire Mary V 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R		or City or Town Str	ate Zin Code)
	Ith and 27 is r		Tyrone W. Taylor (Son) 12809 Jeanne Ct. Fort			
and and	Health em 27 ther tr		20a. Method of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - Cit	
Pages	ni of t: if it		1 Burial 2X Cremation 3 Removal from State 1 Donation 5 Other (Specify) **Chesapeake Crematory** 1 Burial 2X Cremation 3 Removal from State Chesapeake Crematory 1 Donation 5 Other (Specify)	9/2010	eltevill	e, Maryland
mit. Pag	Department of Heal Important; If item 2 any injury or other once.		21. Ignature in Funeral Jervice Licensee 22. Name and Address of Facility 7.			
permit.	Important in support		3447 14th St. N.W	n. Bacon . Washing	eton. DC	20010
*9	為。持		A carry the disease, ovcomplications that caused the death. Do not enter the mode of dying, such as cardia slock, or hear failure. List only one cause on each line.			Approximate Interval Between
Dh	voicion		splock, or heart failure. List only one cause on each line.	. time		Onset and Death
	ysician Medical		impressible ause (Final disease of condition fesulting in death) a. Acute myocardial info Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	1/2//001		Juana
Ex	aminer		Atheroreleration heart d	Wease		years
	er were	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause or in jury			J
cute	nd ransi	Examiner	triat initiated events			years
6/6U , ate be executed	attending physician and for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):			/
o / oU, ate be ex	hysic the b	dicai	d			
	ding p	Me	IF FEMALE: 23c. If yes, outcome of pregnancy		22d Date	of dollars
ath cer	for us	ian/	23b. Was decedent pregnant in the past 12 months? 1		23d. Date of Month	-
be de	the	hysiclan/Me	1 Yes 2 No 9 Unknown	-		
The law requires that the death certific	been signed by the attendir should be detached for use	0	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contrib	ute to the cause of death?
HECOLOS,	sign td be	d by	Diabetes mellities 2	10	Yes 2 No 3	☐ Probably 4 ☐ Unknown
¥ 70 V	beer	Completed		24a. Was		re autopsy findings available
he a	certificate has rector, page 2	ш			rmed? dea	or to completion of cause of ath?]Yes 2□ No
	ificati or, pë	O O	25. Was case referred to medical 26. Place of De	1 ☐ Yes eath (Check only o		1165 2010
/sicia	s cert direct	o B	examiner?		dence 6 Other	(Specify)
g P _y	er thi	n: 1	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at	28d. Describe	how injury occurred	
VISION Attending	ath. r: Aft se fur	atio	2 Accident investigation M 1 Yes 2 No			
Z Atte	recto by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)	28f. Location (City or To		or Rural Route Number,
2 🖁	rs aft ral Di led in	Cer				
Hosp	within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.)			
the	thin 2 the mplet	Med	29b. Signature and title of certifier 22c. License number		29d. Date signed (Month, Day, Year)
P	¥ 5		D1228	0	5/1	8/2010
1	5		20 Not and address a supposed to the state of doubt (Nom 22a) The Critical		5/11	7,20,0
do	+		29b. Signature and title of certifier D 2278 30. Napple and address Person who completed cause of death (Item 23a) (Type, Print) For M Schrister MD 7500 Greenway Cf 31. Date filed (Month, Day, Year) 32. Registrar's Signature	4 Dr. C	Krenbel	4, MO 20770
1	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Regist		31. Date filed (Month, Day, Year) NAY 2 0 2010 Sesser 32. Registrar's Signature			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5/14/2010 Physician/ Margarete L. Fuchs 820am M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Crofton Crofton Care Arundel 6. Sex 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2**X**XF 85 Months Hours Min. (Month, Day, Year) 1/18/1925 Country) Germany 217-80-9622 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits hours after death with the Maryland Director 1 🗌 Yes 🗶 🛚 No Grasonville MD. Queen Anne 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? the Medical Examiner must be 23a Funeral 21638 USA 4003 Main Street items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. Yes 2 XNo "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XXNo Specify: White If Yes, Give XX Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Marie Anna Siegel Paul Optiz permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 620 Crawfords Ridge RD. Odenton, MD 21113 19a. Informant's Name/Relationship (Type, Print) 620 Crawfords Ridge RD. Daughter Heidi Brotherton Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 🙀 Cremation 3 D Removal from State 5/18/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitHardesty Funeral Home, P.A. 15 Annapolis, MD 21401 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph, sician/ mon disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence Exami law requires that the death certificate be executed the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23h Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 Live Birth 2 Live of death Month Day been signed by the should be detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy Hospital or Attending Physician: The 1 Yes 2 No Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA ပ 1 Tes Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State

ravi

29b. Signature and

32. Redistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2225

Registrar

ense thuy, crofton, MD 21114

10-03763 Freddie Helmut			pe or Print i tate of Maryl	and / Dep		f Health	n and						757
Physici		Registrar 1. Decedent's Name (First, Mide	dle,Lest)			Death			2. Date of I				3. Time of Death
Medical Exami	ner	Freddie H			tana				Month May 16		Year		0645 hrs
		4a. Facility Name (if not instituti Prince George's Hos		umber)		4b. City, To Cheve		ocation of Dea	th		c. County or Prince G		s
Funeral		Social Security Number	6. Sex	7. Age (In yrs	. last birthday)	If Under		If Under 24H	rs. 8. Date of				place (State or
Director		Unknown	1 XM 2 F	35	Yr	Months s.	Days	Hours Mi		er 26,			Peru
		Usual Residence of Decedent		I			J						
w any		10a. State 10b. County			ty, Town or Loca								10d. Inside City Limits
yland -f sho	tor	D.C.		V	<i>N</i> ashington	1 10f. Zip (No. 40			140. 00			1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fitten 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	2809 Evarts Str	et NE			200					zen of Wha	at Count	ryr
with th s 23a e notii		11. Marital Status		cedent Ever in	U.S. 13. W	1		anic Origin? (§	Specify Yes or			Americ	an Indian, Black,
death r item	Funeral	1 Never Married 2 X	Married Armed F	orces?			Cuban, I	Mexican, Puert	o Rican, etc.)		White,		
after or all, o	by F	3 Widowed 4 Di	vorced If Yes, Give Ye or Dates:		1 X	Yes 2		specify:			Specify:	e	
hours 'natur		 Decedent's Education (Spinestern) Elementary/Secondary (0-12) 		de completed) 1-4 or 5+)				n (Give kind of OO NOT use re		16b. F	Kind of Bus	iness/In	dustry
136 hin 72 e. than '	ompleted	12) College (1-4 (1 5+)	Weld	er				œ	Construction		
5-0036 lled within 7 Hygiene. I other than	Con	17. Father's Name (First, Middle	e, Last)				18	Mother's Nam	ne (First, Midd	le, Maiden	Surname)		
121 be fil ental F arked	B	Milton Franco					_	Aide Qui					EV - I-U T T
D 21 should the and Mer	입	19a. Informant's Name/Relation Aide Quintana Fi			175			and Number or		-	ity or Town	, State, .	Zip Code)
MD and 2 sho leath and tem 27 is		20a. Method of Disposition	amabuer		D. Place of Dispos			N.E., Willetery,	Date		Location - (City or T	own, State
DOFE ages 1 at of H t: If i		1 X Burial 2 Cremation			crematory or of				22–2010	Bn	entwo	d. M)
Baltimore, permir. Pages 1 an Department of Hea Important: If ite	4	4 Donation 5 Other S 21. Signature of Funeral Service			t. Lincoln	•	tome Inc.						
Per Per in		John 7 K	olel	-	25	04 28th	st.	, N.E., V	NDC 2001	8	. rue	Lat I	DIE IIC.
Physician /Medical		23a. Part I. Enter the disease, o failure. List only one cause		aused the dea	th. Do not enter t	he mode of	dying, sı	uch as cardiac	or respiratory	arrest, sho	ock, or hear	t	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)							_				Death
		Sequentially list conditions,	b.	a consequence	or):								
	miner	if any, leading to immediate cause. Enter Underlying Cause		a consequence	of):								
	Exam	(Disease or injury that initiated events resulting in death) Last	C.	a consequence	of):							- 2	_
i, P.O. Box 68760, ires that the death certificate be executed signed by the attending physician and the detached for use as the burial - transit.			d										
O, be ext sician surial -	edical	UNPENDED	AMENDED										
Box 68760, e death certificate be the attending physic ed for use as the bur	Ž	IF FEMALE: 23b. Was decedent pregnant in t	he 23c. If yes,	outcome of pre		tal death	3	Ectopic pregn	ancv	230	d. Date of d Month	lelivery Da	y Year
X 6.	Physician/M	past 12 months? 1 Yes 2 No 9 Un	denous	nant at time of o	death -	her (Specif							,
. BC the degraph of the graph o	Phys	Part II. Other significant condi	9		resulting in the i	ınderlyina c	ause aiv	en in Part I	23e Di	d tobacco i	use contrib	ute to th	e cause of death?
P.O.	ā	· · · · · · · · · · · · · · · · · · ·	don't contributing t	o addin bat not	regularing in the	andony ing o	adoc giv	OTT ITT GIVE.					bly 4 Unknown
ords, w require is been si should b	eted				.= -				24a. W				psy findings available
SCOI re law te has i	Completed					· · · · · · ·				topsy erformed? es 2 No	de	ath?	mpletion of cause of
n: The rtifical tor, pa		25. Was case referred to medical	al		_	26	.Place of	f Death (Check		is Z N	0 1 1	✓ Yes	2 140
Division of Vital Records, at or attending Physician: The law requires after death. al Director: After this certificate has been so led in by the fameral director, page 2 should by	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient	3 DO	A Of	ther Nursi	ng Home 5	Reside	nce 6	Other:	
fing Phy After ti	Jn: T	27. Manner of Death 1 Natural 5 Res	28a. Date (Month	of Injury n.Day Year) 2010	28b. Time of I 0328 hrs			at Work?	28d. Descrit Subject s		iry occurre	d	
isior Attend or death. rector: by the	Certificatio	Pen	stigation		home, farm, stre			s 2 No	29f Locatio	n (Street n	nd Number	os Dure	I Boute Number City
Divi	rtifi	dete	id not be	Local Stre		et, ractory, o	mce buil	iding, etc.		n. State)			Route Number, City
Hospie 24 hour Funer tely fill		29a Certifier	hysician: To the be			red at the ti	me, date	and place, and					l.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executivithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the finneral director, page 2 should be detached for use as the burial - tri	Medical	Circuit Cirily	aminer: On the basis and manner s	of examination									
- F 3 F 3	ž	29b. Signature and title of certifi		2			icense r						h, Day, Year)
5		ny	~~, I	(20)			D.C.M.	.E.		May	17, 201	0	
(4)		30. Name and address of person Ling Li, MD Assista	n who completed cau ant Medical Exa		_{m 23a)} 1 Penn Stree	et, Baltim	ore. M	D 21201					
St	ate	31. Date filed (Month, Day, Yax)			turghards	A	-,						
Regist	rar	MAY 2 1 20	IU Kymer	w.	7								

Registrar

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar 29b

nature and title of certifie

Laron Locke MD.

31. Date filed (Month, Day Year MAY 21

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 19, 2010

and manner stated

Assistant Medical Examiner

Registrar's Signature

and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23c,d per doc g904 6-22-20 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MMonth 22. **2010** Phv11is Fredericks 12:11 P M Train Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's 3310 25th Avenue Temple Hills If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 XF Country Kansas M17/27/1925 84 509-22-2045 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Temple Hills 1 Tes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20748 Funeral 3310 25th Avenue USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black White etc ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White 3XXWidowed 4 □ Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ in Home Homemaker Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ August Train Magadeline Charnstrom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Llovd Fredericks / Son 7805 Pinewood Drive Clinton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 06/01/2010 21. Signatural Funeral Service License 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Maryland 20745 a 11. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ck, or heart failure. List only one cause on each line. diate Cause (Final Physician/ Cardiones Prooting Medical resulting in death) Due to (or as a consequence of) Examiner many anten Sequentially flot conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of) attending physician Physician/Medical above Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ ó in the past 12 months?
1 Yes 2 X No Month Day 4 Pregnant 9 Unknown Pregnant at time of death signed by the a 1 ☐ Yes ∠ L g ☐ Unknown the ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4¥¥Unknown Completed should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy has death?

1 Yes 2 No certificate Yes 2 X No **Division of Vital** funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: After 1 X Natural iniury 5 Pending 24 hours after death. Funeral Director: A 2 Accident
3 Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atter within 24 hours after der To the Funeral Director completed filled in by the 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 0-0024687 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOR 6357 Oxon Hill Rd. Oxon Hill, Maryland 20745 32. Registra s Sign Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day JOSE Medical MARCELINO 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 326-86-6354 1 🛛 M 2 🗆 F Months Days Hours Min. 03-15-1962 Director 48 Vrs E1 Salvador Usual Residence of Decedent 28a-f shov 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Frederick Frederick 1X Yes 2 ☐ No 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1532 Andover Lane 21702 Salvador 'natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Completed by 1 X Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 1X Yes 2□No Specify:salvadoran 3 🗆 Widowed 4 🗆 Divorced If Yes, Give Year or Dates Specify:Hisp**anic** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry t of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 0 Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nicolas Guzman Maria Santana Del 19a. Informant's Name/Relationship (Type, Print) (Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jose R. Guzman Del Cid 1532 Andover Lane, Frederick, Maryland 21702 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ō permit. Page Department of Important: If any injury or 4 Donation 5 Other (Specify) Family Cemetery 05-27-10 El Salvador 22. Name and Address of Facility W.H. Bacon Funeral Signature Home, Inc. 3447 14th St. N.W. Washington, DC 20010 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. shock, or heart failu Immediate Cause (Final Approximate Interval Between Ph_sician/ Onset and Death disease or condition resulting in death) Anoxic ence Medical Due to (or as a consequence of) Examiner Sequentially list conditions # any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as a consequence of Examir the burial-transit o ca that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: nse s 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery Hospital or Attending Physician; The law requires that the death for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has performed?

Yes 2 No 1 Yes 2 🗌 No director, 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) 1 🗌 Yes 2 X No Other: ဂ္ 1 🔏 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director; At completed filled in by the fu Accident 1 ☐ Yes 2 ☐ No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifier ڡ 29d. Date signed (Month, Day, Year) 2010 MDD 35106 30. Name and addess of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Hee

ung

Date filed (Month, Day Ye

Frederick, mo 21701

400

32. Registrar's S

		For State Registrar					Cei	rtificate of	υeat	h		Reg. No	.4. U I	U	1101)
hysici		1. Decedent's Name Betty Lo	(First, Middle, l Ou Geir								2. Date of De Month May 15	Da		/ear	3. Time of Death 11:45 P ^M	
Medi xamir		4a. Facility Name (If Carroll I			nd number) House			4b. City, Town, o	r Location		ray 15	4c	. County of	Death	11.40 1	
neral		5. Social Security Nu	ımber 6.	Sex 1 □ M 2√2	7. Age	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Und	er 24 Hrs. s Min.	8. Date of Bi	rth 57, Year	930		ace (State or Foreign	7
tor		214-24-62 Usual Residence of I				10c. City,		cation							d. Inside City Limits	_
Name of	Director	MD	Carroll	L		Finks									1 ☐ Yes 2 ☐ No	
		10e. Street and Num 2521 Carr		Rd.				10f. Zip Code 21048				10g. Ci	•A•	at Countr	y?	
	by Funeral	11. Marital Status 1 ☐ Never Marrie 3 ☐ Widowed 4		Arme 1 □ \ If Ye:	Decedent E ed Forces? Yes 2 3 N s, Give r or Dates:	ver in U.S.		Was Decedent of I If Yes, specify Cub 1 □Yes 2 X No			cify Yes or No Rican, etc.)	D-	14. Race Black, Specify:	America White, et	c.	
	Completed by	(Specia	15. Decedent's fy only highest of	Education trade comple	eted)		(Give	dent's Usual Occup kind of work done DO NOT use retire	during m	ost of workir	ng	16b. K	(ind of Busi	ness/Indu	ıstry	
	Comp	Elementary/Secon			ege (1-4or 5-	-)	Homer		,				n_Hom			
	To Be	17. Father's Name (F Harry Ada	First, Middle, La BMS	st)					18. Ma Ma e	ther's Name Mario	(First, Middle Will:	, Maider Lams	on Surname) On)		
		19a. Informant's Nar J. Russel				- 1		ng Address <i>(Street</i> Carrollt							Code)	
		20a. Method of Dispo		Removal	from State	1		sition (Name of matory or other pla		! !	ate		ocation - C	•		
once.		4 ☐ Donation 5	neral Service Lic			Lake		Memorial Name and Addre Pritts F 412 Wash			20/2010 me_& Cl					
		23a. Part 1. Enter the	1	mplications to	that caused	the death.			_				ter,		1157 Approximate Interval Between	
		Immediate Cause (F disease or condition resulting in death)	Final	_ a	LEF	TS	-	24C H	ema	TOW	4				Onset and Death	
r		Sequentially list cond	ditions.	b		TICOA	aola	tion H	1-67	apy						
	Examiner	Sequentially list condif any, leading to immoduse. Enter Underl Cause (Disease or in that initiated events	nediate lying njury	DL C	ue to (or as a	conseque	nce of):									
	_	resulting in death) La	ast	d.	ue to (or as a	conseque	nce of):									
	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 n 1 □ Yes 2 2 1 9 □ Unknown	nonths?	23c. If ye.	s, outcome of Live birth of Pregnant at Unknown	2 🗌 Fetal d	eath 3	☐ Ectopic pregnand ☐ Other (specify) _	су				23d. Date Mont		y Day Year	
	þ	Part II. Other signific	cant conditions	contributing	to death bu	t not resulti	ng in the u	nderlying cause gi	ven in Pa	rt I.					e cause of death?	
	Completed		/ NECK		Ducui	41100					24a. Was	s an	24b. W	ere autop	sy findings available	
	e Con	25. Was case referre	ed to medical	1					00 81	and of Doorth	perf 1 □ Yes (Check only	ormed? 2 ☑ N		ath? Yes	2 □No	_
	10 B	examiner? 1 ☐ Yes 2 ☐	Vo	Hospital:				" 3 DOX	ner: 4 🗆	Nursing Hor	me 5□Res	idence		· · · · · · · ·	Dovelpr	86
	ation:	27. Manner of Death 1 □ Natural 2 □ Accident	5 ☐ Pending investigat		Date of Injur (Month, Day		8b. Time o Injury	Wo	ryat rk?]Yes 2		28d. Describe	how inju	ary occurred	d		
	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine		Place of Inju building, etc	ry - At hom . (Specify)	e, farm, str	eet, factory, office		2	28f. Location City or To	(Street a	ind Number te)	r or Rural	Route Number,	
	Medical C	29a. Certifier (Check only one)	1 CertifyIng 2 Medical Ex	aminer: On	To the best of the basis of I manner sta	examinatio	edge, deat n and/or in	h occurred at the to vestigation, in my	ime, date opinion,	e and place, death occurr	and due to th ed at the time	e cause(e, date ar	s) and mar	ner as st nd due to	ated. the cause(s)	
/	Me	29b. Signature and to	itle of certifier	k. (Scale			29c. Licen	5			29d. D	ate signed		oay, Year) ►5/19/201	0
		30. Name and addre		0	-	ath (Item 2	3a) (Type,	Print)	1812	Aven	e v	4ST	mins	ī en	21157 MARY 1/2	~(
Sta		31. Date filed (Month	h, Day, Year)		32. Registra	r's Signatur	re &	6. 41								
gistr	वा		MAY 20	2010	Chris	m ,	D. 4	Dave.				_				

okasis per M.E. (per T.T.)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John Robert Gant, Jr. 0344 M MA 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Leverle Trince Prince 6 cores If Under 1 Year | If Under 24 Social Security Number 6. Se 8. Date of Birth (Month, Day, 1**⊠**M 2□ F Months Days Hours 228-52-8626 67 Dec. 16, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 421 Kettering Drive 20774 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Specify: **Black** Specify: 3 ☐ Widowed 4 ☐ Divorced 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government 12th Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Gant Gladys Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 Emma Gant/ Wife 421 Kettering Drive Upper Marlboro, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery 2010 Brentwood, Maryland 21. Signature of Funeral Seri 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final

Physician /Medical Examiner

Department of Health and Men Important: If item 27 Is marke any injury or other traumatic

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show

ral", or items 23a or Examinar must be r

Director

Funeral

Completed by

Be

ဂ္

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Examine burial-trar Physician/Medical signed by the a d be detached for Completed by certificate has page 2 s æ After this c funeral din Certification: To within 24 hours after death.

To the Funeral Director: All completely filled in by the fu

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

disease or condition resulting in death)	a. Conshary Antery Dise	ial	
resulting in death)	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b		
that initiated events resulting in death) Last	c		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregnancy 1		23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
		24a. Was an autopsy performed?	
25. Was case referred to medical examinar?		ath (Check only one)	
1⊟ Yes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing H	Home 5 Residence	6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident investigation		28d. Describe how inj	ury occurred
3 Suicide 6 Could not b 4 Homicide determined		28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exam	hysician: To the best of my knowledge, death occurred at the time, date and plac miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	e, and due to the cause urred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)

140055

29d. Date signed (Month, Day, Year)

State Registrar

Medical (

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Registrar Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5/14/2010 Physician/ Doris Anne Gies 7pm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 1009 Dockser Dr. Crownsville Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min Director 220-18-6126 82 Usual Residence of Decedent show 10a, State 10b. County aţ 10c. City. Town or Location 10d. Inside City Limits Director or 28a-f sh notified a MD Anne Arundel Crownsville 1 Yes XX No 10e. Street and Number 10f. Zip Code r must be r 10g. Citizen of What Country? Funeral 1009 Dockser Dr. 21032 USA "natural", or items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Saltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 KNo Specify: 3 Nidowed 4 Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Banker Banking other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental F permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve မ Melvin Edward Snitzer Catherine Elizabeth Sweglar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George A. Welsh III 1009 Dockser DR. Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 🗌 Removal from State Atlantic Crematory 5/18/2010 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hardesty Funeral Home, P.A. Signature of Funeral Service 3 Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Ridgely Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition LOGI Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Pregnant at time of death 5 Other (specify) Day Year 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? tension Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 29a. Certifier Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 5116 010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4201 Mitchellville Rd. Konni E. Bringman Bowie, MD 20716 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MAY 20Î0 00:53 a™ Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Prince Georges Clinton Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Bay, 1 🕱 M 2 🗆 F Months Days Hours Country) Director Sep VA 229-42-3234 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Clinton 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20735 7520 Surratts Rd. USA Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced Specify: **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Engineer Wachovia Be and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eugene Givens Cleo Hines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a item 27 i Ella Glover - Daughter 5733 29th Ave #202 Hyattsville, MD. 20782 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1
Department of
Important; If it
any injury or o Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans 5-25-2010 Cheltenham, MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, MD. 20746 23a. Part 1. Enter the disease, or co. plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence of, Cause (Disease or linjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 the as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy5 Other (specify) in the past 12 months? Month the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performi 1 Yes 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Marient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physilia 24 hours after death.
To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? Division 2 🗌 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the unite, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

State

Print)
lising the Rd # 10/ ft LAT histe My 7076

10-03768 Ismael G

i.	Please Type or Print in Black Indelible Ink. Ensure All Copies Are	Legible.	
arcia Garcia	State of Maryland / Department of Health and Mental Hygiene		767
1- For State Registrar	Certificate of Death	Reg. No.	
bygleign/ 1 Decedent's	Name (First Middle Last)	f Dogth	2 Time of Death

		Registrar				Centi	ficate o	T Deati	7				Reg. N	0.		
Physici Medical Exami		1. Decedent's Nam		_{le,Last)} Garci	a	Ga	arcia		-			2. Date of D Month May 16,	Day	y Year		3. Time of Death 2049 hrs
		4a. Facility Name (number)			4b. City, T Westr		Location of er				4c. County o	Death	
Funeral Director		5. Social Security I	Number	6. Sex	1	(In yrs. last	t birthday)	If Unde	r 1 Year		24Hrs. Min.			M/DD/YYYY)		hplace (State or
Director		none Usual Residence of	f Decedent	1 X M 2 F		19 —	Yr		1	Thousand .		11/3		1990	Coi	nMexico
any		10a. State	10b. County				own or Loca								- 1	10d. Inside City Limits
ne Maryland or 28a-f show any Iffed at once.	tor	MD	Carr	oll		Wes	stmin ——								_	1 Yes 2 No
the Mar ta or 28s	Director	10e. Street and Nu 2611 7		own Ro	oad			10f. Zip 21	158					Citizen of What Country? Mexico		
ath with tems 23	uneral	11. Marital Status 1 X Never Marri	ed 2 M		Forces?	er in U.S.				panic Origin , Mexican, P						can Indian, Black,
after de al", or i	by Fu	3 Widowed		orced If Yes, Give Yor Dates:	ear 2	X No	1 🔀	Yes 2 No specify:						Specify:		White
hours natur	ed k			cify only highest g			6a. Deceder	nt's Usual (ccupati	on (Give kir DO NOT us	nd of wo	rk done	16b.	Kind of Bus	iness/Ir	ndustry
036 ithin 72 me. r than " fedical I	Completed	Elementary/Seco	ondary (0-12)	College	(1-4 or 5	+)		inter				-,		Buildings		
15-0 filed w Hygie d othe		17. Father's Name		•	T				1	8.Mother's						
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica	o Be	Ismael				eroa		n Address	/Street	Jua		Gar	cia	Acc	sta	^{Zip C}
MD nd 2 sho ulth and m 27 is aumati		Margar	ito F	uentes	Garc		3003) ! 31	in S	tree	t A	pt.!	на	rrisb	ur	g,PA.
Baltimore, permit. Pages I ar Department of Hee Important: If ite		20a. Method of Dis	Cremation		from Stat	e Mur	ce of Dispos matory or ot 11C1D	her place) a T				^{0ate} 2010	Sa	Mami ngui	j uā	les,
Baltin permit. P Departme Importan injury or		4 Donat on 5 21. Signature of Fu	Other Service			<u> Sar</u>	ıguij PH	uale TETP	S Address	rinai	DI	FUNE	<u> Mi</u> RAI	Choad SERV	can VIC	<u>,Mexico</u> E,P.A. g,Md20910
Physician	-	23a Part I Enter t	ediséase or	complications that	caused t	he death Do	92	41 C	olu	mbia	Bl	d.Si	lve	er Spi	rin	g, Md20910
/Medical Examiner		failure. List of ly one cause on each line. Immediate Cause (Final disease a. Drowning Complicated by Hypothermia												Between Onset and Death		
LXammer		or condition resulting	ng in death)	Due to (or as	a consec	quence of):									-	
·	iner	Sequentially list con if any, leading to im cause. Enter United	mediate	Due to (or as	a consec	quence of):										
ecuted and rransit	in/Medical Examine	(Disease or injury the events resulting in the	nat initiated	Due to (or as	a consec	quence of):										
ial ial	dical	UNPENDED		d AMENDED)			_							_	
8760, tificate being physic as the bur	§	IF FEMALE: 23b. Was decedent	pregnant in th	23c. If yes		e of pregnan			з Г	Ectopic pr			23	3d. Date of de		
	Physicia	past 12 months		4 Preg	gnant at ti	me of death	- =	tal death ner (S <i>peci</i> i	_		egnanc	y 		Month	Da	ay Year
O. B. It the de by the ached f		Part II. Other signif		aouk	nown to death I	but not resul	Iting in the u	nderlying o	ause giv	ven in Part I		23e. Did	tobacco	use contribu	ite to th	ne cause of death?
83 .00 0	d b										_	1 Ye	s 2	✓ No 3	Proba	biy 4 Unknown
of Vital Records, ng Physician: The law requir Mer this certificate has been si meral director, page 2 should t	Completed											24a. Was auto				ppsy findings available mpletion of cause of
tal Rec	팅											1 ✓ Yes	ormed? 2 N		eth? Yes	2 No
Vital ysician: his certifi director,	Be	25. Was case referr examiner?	ed to medical	Hospital: 1		. C3				of Death (Ch			1	r=1		
n of Viding Physica. After this funeral dir	읽	1 Yes 2 27. Manner of Death	2 No	28a. Dat	e of Injury	28	VOutpatient			other N			,	ence 6		
~ = 3 ^ ∉	ation	1 Natural 2 ✓ Accident	5 Pend	Mar (Mgr)	h, Day Yea 5, 2010	17	749 hrs			es 2 🗸 No	Su	bject dro virenmer	wned	and expo	sed t	o cold
Division tal or Attendit rs after death.	Certification:	3 Suicide 4 Homicide	6 Could	not be 28e. Pla	ce of Inju		, farm, stree	t, factory, o	office bu	ilding, etc.		or Town.	State)	n Road, W		l Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 (Check only		ysIcian: To the be	est of my l	knowledge, d					and due	e to the cau	se(s) ar	nd manner as	stated	l.
	Medical	one) 2 🗸		niner: On the basis and manner		nation and/c	or investigat		icense		ed at th	e time, date		Date signed		
2		my	ha	m.D					O.C.M					y 17, 2010		· · · · · · · · · · · · · · · · · · ·
		30. Name and addre		who completed can		,	a) enn Stree	t. Baltim	ore M	ID 21201						
Sta	te							-	J, G, W							
Registi	ar	31. Date filed (Mont)	217	UIU Den	was	1.	park									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** GREEN 10 12.30 AM BIFRINA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Bethesda Health & Rehabilitation Ctr. Bethesda If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number **Funeral** Months 1 □ M 2 🗙 F North Carolina 1924 Director 30, 243-16-4754 85 Aug. Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No Director Washington DC 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 72 hours after death with 20002 243 Warren Street NE United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married African 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 □ Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within; the and Mental Hygiene.

7 is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Matthew Mitchell Ruth Midgett ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is m any injury or other traum 2891 Hackney Lane Waldorf, Maryland Stanley Green/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Harmony
Memorial Park 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 DRemoval from State 22, 4 □ Donation 5 □ Other (Specify) Landover, Maryland 21. Sin ture of Funeral Service Licens 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMUNIA ASPIRATED Physician WK. /Medical Due to (or as a consequence of): Examiner VASCULAR WRE CEREBRU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar and be exect Due to (or as a consequence of) physician Physician/Medical the as. IF FEMALE: ase 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9 I Inknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à ATRIAL PIBLILATION 2₽No 3 Probably 4 Unknown 1 🗌 Yes Completed ANEMIA 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No certificate has 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Tes 2 No Hospital Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Inpatient Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation Hospital or Attendi 24 hours after death. Funeral Director: A death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide JE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760, 24 hours a To the within 2

Saltimore, Maryland 21215-0036



State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) **Chargeson** W 7830. M.D

D. 17656

29c. License number

29d. Date signed (Month, Day, Year)

5/21/10

and manner stated.

Ch M

GEURGETOWN ROAD & CIS, BETHESDA MD JOSI4

29b. Signature and title of certifier

Dr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 23a per phys. G905 7719/10 dk

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 🧷 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May Month Physician/ Dong 2010 Suk Han 17, 10:30A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 304 Careybrook Lane Prince George Oxon Hill 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🗓 F Days Hours 4/3/1925 85 217-19-4544 South Korea Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County should be filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George Oxon Hill 1 ☐ Yes 2 🕅 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6482 Bock Road 20745 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Asian/Korean "natural", 3 Midowed 4 □ Divorced Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Young Tak Han Sun Ei Park 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Florence D. Gee/Sister 6482 Bock Rd. Oxon Hill, MD. 20745 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from Stat Resurrection Cemetery 5/22/2010 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home f Funeral Service License 6160 Oxon Hill Rd. Oxon Hill, MD 20745 Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Physician. Medical Due to (or as a consequence of) **Examiner** Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Renal Failure that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 2 🗆 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Home Pastor's 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral D Medical 29a Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 □ 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 018092 05-17-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ihn Whan Roh, M.D. 5107 Silver Hill Rd. Suitland, MD. 20746 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

MAY 9 0 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene AMEND ITEM#24a, per PHYS. G905-772, 2010, WS 2. Date of Deal 3. Time of Death **Physician** Month रस्डि (S ی /Medical (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/24/1931 9. Birthplace (State or Foreign **Funeral** 1**x** M 2□ F Mary Land 215-28-0134 78 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-f ahow must be notified at 10d. Inside City Limits 28a-fahow Maryland Anne Arundel Annapolis 1 XYes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 930 Bay Forrest Court 21403 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Exeminer: Black, White, etc. 1 Yes 2 No 49-52 If Yes, Give Year or Dates: 1 ₩ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: ģ Specify: White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Painter Shipyard 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Sumame) Mental Pages 1 and 2 should Alonzo Hubbard Agnes True 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 l Douglas Hubbard - Brother 1435 Second Ave, Des Plaines, IL 60018 or other Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Department Important: hany injury o Baltimore Crematory 5/21/2010 Baltimore, MD permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Mychin T. Klober 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the more of dying, such as lardiac or respir nor varrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Je Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transit and Due to (or as a consequence of) signed by the attending physician I be detached for use as the buria 68760 Physician/Medical Box IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate has 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours atter death.

To the Funeral Director; After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death Check only one Hospital: Inpatient 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury 1 Yes No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 0 15 3+1 30. Name an use of death (Item 23a) (Type, Print) person 20 31. Date filed (Month, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May 2010 Thomas Earle Hitchcock 11:51a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 455 Telegraph Rd. Rising Sun Cecil Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 F Hours Sept. 17,1946 Country) 215-44-0958 **Director** 63 Yrs MD Usual Residence of Decedent shov Important; If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛣 No MD Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21911 USA 455 Telegraph Rd. permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry J Mental Hygiene. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2121 Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Marine Corp. U.S. Military Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frances Fahey Powell Raymond Hitchcock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 455 Telegraph Rd. Rising Sun, MD 21911 Fern Hitchcock /wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 5/2772010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens Aberdeen, MD ral Service Licensee Name and Address of Facility R.T. Foard Funeral Home, P.A 11 S. Queen St. Rising Sun, C-23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or a a consequence of) Examiner Sequentially list conditions, if any, reading to inmediate cause. Enter Underlying Due to (or as a donsequence by Exam attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death 1 Yes 2 L 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 of autopsy performe 2 No Yes 2 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 No after death Accident Investigation Suicide within 24 hours after de To the Funeral Directo completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29c. License number

104 1AY

State Registrar and address

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Month May 13, 1745 David Harley Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 8500 Mike Shapiro Dr. # 429 Clinton Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 25, 1922 9. Birthplace (State or Foreign **Funeral** 1 🗷 M 2 🗆 F Hours Min. 87 Pennsylvania Director 237-20-1534 Dec. Usual Residence of Decedent 28a-f show ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No Clinton Maryland | Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20735 8500 Mike Shapiro Drive # 429 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African 1 ☐ Yes 2 A No Specify. 3 Divorced 4 Divorced Completed American Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Teague Daisy Harley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1754 Forest Park Drive District Hghts., Md. 20747 Veronica McGill/ Daughter Page 1 and 2 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite May 19, 1 A Burial 2 Cremation 3 Removal from State Brentwood, Maryland 4 Donation_5 Other (Specify) Lincoln Cemetery 2010 21. Signature of Funeral Strvica Licente 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIO MYO PATHY Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner HYPERTENSION Securitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PROSTATE CANCER 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown DISEASE ARTERIAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N UBSTRUCTIVE DISSASS CHRONIC 1 Yes 2 No 25. Was case referred to medical examiner? Be director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation completed filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only on and title of certifier 29b. Signatur မ 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) SURRA775 AMANAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0:39 PM Hohensee Warren G. 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 5. Social Security Number CHARLES MEDICAL CENTER Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 11/28/1935 7. Age (In yrs. last birthday) **Funeral** Months Hours Days Min. 218-30-4923 Maryland 74 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 □Yes 2 No ral", or items 23a or 28a-f sh Examiner must be actified Maryland St. Mary's Charlotte Hall Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? USA 20622 29449 Charlotte Hall Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No 1957 − If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes 2 No "natural", or Specify Specify: White 3 Widowed 4 Divorced er than "nature the Medical E 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withi Health and Mental Hygiene. Retail Self-employed ilth and Mental Hygier 27 is marked other the traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hohensee Mary Vovtko ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau Brandon T. Donahue/Son 7506 H St. Chesapeake Beach, MD 20732 20b. Place of Disposition (Name of cemetery, crematory or other place)
Kalas Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Edgewater, Maryland 5/19/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Funeral Service Ligenses alus 6160 Oxon Hill Rd. Oxon Hill, MD 20745 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, pr complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RESPITORY UNKNOWN **Physician** ACUTE /Medical Due to (or as a consequence of) Examiner Respirtor Distress Sympsome UN KNOWN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine STAGE Chronic Obstructive Purnonary Disease LIND KOK OLLEN burial-tra Due to (or as a consequence of) physician the burial LAKKNOWN Physician/Medical MONARY attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ APNED 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy to alikes Diabetes 1 ☐Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? After t 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

filed within 72 hours after death with the Maryland

Hohensee Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed after death.

Director: Aff in by the fur filled in by To the Hospital of within 24 hours a To the Funeral D completely

3

State

Medical

29c. License number

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

7005P5

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

0105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 11711 Livingston Rd. Ft. Washington, MD Samuel Kleiman

and manner stated.

20744

Registrar

29a. Certifier

(Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year John Henry Hamilton 12:54PM MAY 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **BWMC** Anne Arundel Glen Burnie 5. Social Security Number Sex 1XXM 2 □ F 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. une 16 Year) 916 Director 214-18-6011 93 Yrs Marvland Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. anti- if item 27 is marked other than "natural", or items 23a or 28a-f show anti- if item 27 is marked other than "natural", or items be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Maryland Anne Arundel Gambrills 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1058 Rt. 3 North 21054 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black. White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 6th Salvage Entrepreneur Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Benjamin Hamilton Caroline Queen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cora Gray (Daughter) 8104 Ouarterfield Rd. Severn, Md. 21144 20a. Method of Disposition 20b. Plate of Disposition (Name of 20c. Location - City or Town, State Date Important: If if any injury or o 1 X Burial 2 Cremation 3 Removal from State Memorial Church 5-19-10 Gambrills, Md. 4 Donation 5 Other (Specify) permit. F 21. Signature of Funeral Service Licenses Windame Recasse of Secilisions Mortuary, P.A. Jarry & Rees MOOY 83 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Due to (or as a consequence of): ARTERY Medical Examiner Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DENENTIA 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? PIABETES MELLITUR 24a, Was an After this certificate has 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Magner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural iniurv 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month. Day, Year) MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) te loy milkersville and

Registrar

State

31. Date filed (Month, Day Year)

MAY 1 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Ull U

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D201<u>0</u> Physician/ MAY 17. **JOHN** WILSON HARPER 10:14 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S DOCTORS HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 **XX**M 2 □ F Months Davs Min. WASH ... 5-24-1931 DC 578-42-0428 Director 78 Yrs. Usual Residence of Decedent important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d Inside City Limits Director 1 X Yes 2 No PRINCE GEORGE'S TEMPLE HILLS MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5805 KEPPLER ROAD 20748 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 XXYes 2 □ No If Yes, Give Completed by 1 Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: BLACK Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH GRADE SUPPLY CLERK ARLINGTON NAT. CEMETERY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ OCEOLA MAE HARPER UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TEMPLE HILLS, MD 20748 DELORES A. HARPER-WIFE 5805 KEPPLER ROAD 20b. Place of Disposition (Name of cemetery, crematory or other place)

LINCOLN MEMO. CEMETERY 5-27-2010 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State SUITLAND, MD 4 Donation 5 Other (Specify) PINCKNEY-SPANGLER F. H. 22. Name and Address of Facility 21. Signature of Funeral Service Licenses - 8TH ST., N. E. WASH., DC 20002-5236 524 23a. Part 1. Enter the disease, or complications that caused the death. Deshock, or heart failure. List only one cause on each line. not emer the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine and -transit that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a nsequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Li retail death
Pregnant at time of death
Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 ☐ Yes 2 ☐ No 2 1 N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☐ No Other: ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural injury work? 5 Pending 2 🗆 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check MOD 31528 30. Name and address of person who completed cause of death them 23a) (Type, Print) LANDOVER ROAD MD 20785 6128 N.D. 32. Regin ar's Si State

Registrar DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

Records, P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mynthy 17^{Day} Jordon Roosevelt Hairston 201°0 0120amm Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital ONLEY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 02-15-1939 Days Director 242-58-3689 NC Usual Residence of Decedent 10a. State items 23a or 28a-r sno ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Montgomery Silver Spring 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3210 Norbeck Road USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. δ 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Specify: Black Completed 3 - Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) or other traumatic event, the 4≠ Special Government Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Hariston Irene Barner 19a. Informant's Name/Relationship (Type, Print) 20785 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl ment of Health s tant: If item 27 i 1000 Bright Seat RoadLandover Maryland Ann McNair/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 05/18/10 Riverdale, MD Riverdale Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn and Sons 5635 Eads Street NE Washington, DC 20019 a. 🗲 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest hock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** 70 if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown 2 No Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Multipraan Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed? Yes 2 No 2 🗌 No 1 Tes 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Hospital 2 3 NO Other: 1 🗌 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕒 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2010 on who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 7690 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 James 0scar Holloway, Jr. 19. 4:43 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Prince George's Clinton Southern Maryland Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Days Months Hours Min. Sept. 12, Director Yrs 231-54-1734 67 1942 DC Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10h County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director DC Washington 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1605 Meigs Place NE 20002 United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Examiner , or Black, White, etc þ 1 X Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 No Specify. Black "natural", Completed 3 Widowed 4 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance & Grounds Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 2 James Oscar Holloway, Sr. Ruth Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8006 Ray Leonard Court Landover, Maryland 20785 Ruby Robinson/ Sister Date 27, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lincoln Memorial 2010 Suitland, Maryland 21. Signature of Funeral Service Ligens 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Renal the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Dav Year n signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Sono 3 ☐ Probably 4 ☐ Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform Yes 2 N 1 ☐ Yes 2 ☐ No within 24 hours after death.
To the Funeral Director: After this certifical completed filled in by the funeral director; I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: မှ 1 □ patient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 \sum Yes 2 \sum No Natural 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 D35206 ! Courser 4

Registrar
DHMH 17 Rev 7/2009

State

1701 Civingston Root, Fat was buyon, Maylan

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

un

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year р м 19 2010 Dorothy J. Hunt 05 4:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Thomas More Nursing & Rehab.

5. Social Security Number | 6. Sex | 7. Age (In yrs. last Prince George's Hyattsville Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 □ M 2 🛛 F Months Days Min. Director 102 2/13/1908 Maryland 577-20-3174 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at Director 1 Yes 2 □ No Prince George's MD <u>Hyattsville</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4922 LaSalle Road 20782 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2★ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2**X** If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. þ Specify: 3 X Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than "other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) <u>Beautician</u> <u>Private</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Estell Brown 2 Richard Dorsey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tra Cresenda Jones - Granddaughter 81 Village Green Way Hazlet, NJ 07730 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery | 5/22/2010 Brentwood, MD 22. Name and Address of Facility Ft. Lincoln Funeral Home, Inc. 21. Signature of Funeral Service Licensee 23a. Part 1. Inter the disease or complections that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 3401 Bladensburg Road Brentwood, MD 20722 Approximate Interval Between Onset and Death Immediate Cause (Final hysician ARTERIOSCIERONO disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, fland, beauty cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical Completed by page 2 has Be Certification: To

the Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this certificate within 24 hours after death,

To the Funeral Director. After thi
completely filled in by the funeral

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	significant conditions contributing to death but not resulting in the underlying cause given in Part I. Constructive Cons							
Part II. Other significant conditions	contributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?			
Alzheimeris i)	(3612			1 ☐ Yes 2	Ño 3□ Probably 4□ Unknown			
		Sitense		autopsy performed?	death?			
25. Was case referred to medical examiner?	<u> </u>			ath (Check only one)				
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient 3 □ I	OOA Other: 4 Nursing I	Home 5 Residence	6 ☐ Other (Specify)			
27. Manner of Death 1	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injur				
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	28f. Location (Street an City or Town, State	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) Certifying Ph	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigati	ed at the time, date and plac on, in my opinion, death occ	ce, and due to the cause(s curred at the time, date and) and manner as stated. I place, and due to the cause(s)			

29c. License number

101852

4203 Quelassony Rolly Gittsv:14 MD 20781

29d. Date signed (Month, Day, Year)

MAY 20, 2010

Registrar DHMH 17 Rev 1/2001

State

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, You MAY 2 5 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Aemnd #5, per Fh e904 6/25/10 TT Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Bay Month Year 09:20 **Physician** 2010 Hammond /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month Days Hours Min. 12/1/1975 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** WEST VIRGINIA 234-27-3312 1 XM 2 □ F 34 Yrs. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits INWOOD WV BERKELEY 1 Yes 2 No Director 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 25428 USA 61 CHANNEL DRIVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 A No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Wever Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) WV DEPARTMENT OF Elementary/Secondary (0-12) College (1-4 or 5+) SOCIAL WÖRKER HEALTH & HUMAN SERVICES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be LARRY STEVE HAMMOND FRANCES CHARLENE BENNETT မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LARRY STEVE HAMMOND/DAD 729 NEAR BETHELS WAY, MARTINSBURG, WV 25405 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 6/1/2010 CEDAR GROVE CEMETERY INWOOD, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility BROWN FUNERAL HOME, PO BOX 821, Coppe 327 W. KING ST., MARTINSBURG, WV 25402 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiapulmanary sarcaid **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any local cause. Enter Underlying Cause (Disease or injury Examiner Disk to (or as a consequence of) as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: use a 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 - Fetal death Ectopic pregnancy 4 Pregnant at time of death
9 Unknown in the past 12 months? Day Year 5 Other (specify) signed by the at ald be detached f Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 № No 3 Probably 4 Unknown 1 Tyes Completed should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate has page performed? 2 WNo 1 Yes 2 🗌 No Yes 25. Was case referred to medical director. 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ this filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural (Month, Day Year) 5 Pending investigation death. 2 Accident 1 Yes 2 No Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 - Homicide City or Town, State) Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only completely 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

Venkata 31. Date filed (Month, Day, Year)

Narla M.D.

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

Keso

May 28 2010

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JENKINSON Μ. Month 05 RTLE 1700 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Heritage Harbour Health Center Annapolis Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 1 - M 2 7 F 1/10/1917 Massachusetts 015-05-0761 Yrs 93 Director Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🏋 No Maryland Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3223 Breckenridge Way 21140 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 A No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian Black, White, etc. Be Completed by 1 🕅 Never Married 2 🗆 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced Specify: "natural" White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Assembler A.G. Spaulding Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Annie Jenkinson Maxwell Jenkinson 1 and 2 should be of Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Niland/ Great Niece 3223 Breckenridge Way, Riva, Maryland 21140 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Linenses Fairview Cemetery 5/22/10 Chicopee, MA 22. Name and Address of Facility George P. Kalas Funeral Home Mon Mille 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con equence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami signed by the attending physician and deed be detached for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s death? performed Hospital or Attending Physician: The certificate 2 🗌 No Yes 2 No To the Hospital or Attending Physician: Nwithin 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2. No မ 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific

State Registrar

31. Date filed (Mo 182010

MATEL

EFENSE HIGHWAL

completed cause of death (Item 23a) (Type,

NDAUM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 9 per FH G904 6/17/10 dk

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jackson 11045 am narles 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner renesis College - View Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 6. Sex **Funeral** Year) 1 M 2 □ F Months Days Hours Min Director MD Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-4 ehrem any injury or other traumatic event, Inc. Medicals. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Montgomery Poolesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18740 Jerusalem Church Road USA 20837 Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify þ Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Brickmason Private Companies 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles R. Jackson, Sr. Estelle B. Fisher ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia D. Johnson - daughter 8908 Continental Place, Landover, MD 20785 20b. Place 20a. Method of Disposition of Disposition (Name of ery, crematory or other place) Date 20c. Location - City or Town, State X prial 2 ☐ Cremation 3 Removal fro Jerusalem Church Cem. Poolesville, MD onation 5 Othe (Specify) 5/29/10 22. Name and Address of Facility Snowden Funeral Home nature of Funeral Service 7246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death n. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Hypertensive Heart disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BRITERY Due to (or as a consequence of) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) the burial-trar that initiated events Division of Vital Records, P.O. Box 68760 resulting in death) Last physician attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown à signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed' certificate 1 ☐ Yes 2 No 1 □Yes 2 🗆 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No the i 6 ☐ Could not be 3 ☐ Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Chack only one) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Regist<u>rar</u> rshalee Drive

30. Name and address of person who completed cause of death (Item 23a) (Type,

82. Registrar's Signature

Barbaro A. Noder-Blucker

21

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year Month MAGNOLIA TORDAN Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Casey House</u> Rockville Montgomery **Funeral** Social Security Number 6. Sex Age (In vrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign 1 □ M 2 🖵 F Months Hours (Month, Day, Year) Country) Director 578 <u>Washington DC</u> Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director D.C. Washington 1 ☐ Yes 2 😾 No 10e. Street and Number 10f, Zip Code ō 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Completed by Funeral 618 15th Street, N.E. 20002 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Specify: Black 3 🖵 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. tant: If item 27 is marked other than 'iury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William M. Hardin Dora Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendell Jordan, 116 Fawn Court, son Harrisburg, PA, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ott 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Brentwood, MD 5/27/2010 Fort Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Service Licenses 22. Name and Address of Facility HALL BROTHERS FUNERAL HOME venue. NW Washington 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ End Stage Liver Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hepatitis Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 2 🔀 No 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Septicemia 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 💂 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Atric Fibrillation autopsy performed 2 🗌 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 🙀 No မြ 4 ☐ Nursing Home 5 ☐ Residence 6 ▼ Other (Specify) Hospic 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) R115108 CRNP May 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Diane Ruberi CRNP 6001 Muncaster Mill Road. Rockville, MD

Registrar

10-03958 Haneefah Kareem

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 1 1 State of Maryland / Department of Health and Mental Hygiene

		I - For State Registrar				Ce	rtifica	te of D	eath		,,,		Reg. No).												
Physician	1/	1. Decedent's Name (I										Date of De	Day	Year	3. Time of Death											
Medical Examin		Haneefal 4a. Facility Name (if no				ar)	_	l 4b	City Tour	or Location		May 24,		c. County of Death	0537 hrs											
		Shady Grove		-		ei)			Rockville	or Location	or Death			Montgomery												
Funeral	7	5. Social Security Num	mber	6. Sex	7.	Age (In yrs. I	last birth	day) I	f Under 1 Y	ear If Und	er 24Hrs.	8. Date of E	Birth(MN	M/DD/YYYY) 9. Bir												
Director		579-74-33	352	1 M	2 XX	55		Yrs.	Months D	ays Hours	Min.	Dec	2	Foreig	_{untry)} DC Washingto											
	- 1-	Usual Residence of De												2 1241												
w any	- 1		b. County					r Location	*** 3 *	,					·											
yland -f sho		10e. Street and Number	Monto	Omer	. У	MOII	Lgo	mery					10.0													
e Mar or 28s	2								of. Zip Code				10g. Ci	tizen of What Coul	ntry?											
th with the Maryland ems 23a or 28a-f show any Lbe notified at once.		9404 Pens	snurs			ent Ever in U	.s. T	13. Was D	20886	5 Hispanic Ori	gin? (Spec	ifv Yes or N	U.		can Indian Black											
leath v	nuerai	1 Never Married	2 X X Ma		Armed Force Yes	es?		If Yes,	specify Cub	an, Mexican	, Puerto Ri	can, etc.)		White, etc.												
after d	6	3 Widowed	L	rced If Yes	Give Year	² XX ^{No}		1 Ye	s 2XX	No specify:				Specify: Ame	rican											
hours maturi		15. Decedent's Educ								oation (Give ife. DO NOT			16b.	Kind of Business/I	ndustry											
36 in 72 han "	i de	Elementary/Second	lary (0-12)	C	ollege (1-4 o	or 5+)	_	mema]				,		II												
5-00; led with tygiene other t	Completed	17. Father's Name (Fir	rst, Middle, I	_ast)		· · · · · · · · · · · · · · · · · · ·	HO	memai	rer	18.Mother	's Name (F	irst, Middle,		WN Home												
21215-0036 Judd be filed within 7 I Mental Hygiene, I marked other than ic event, the Medica	υl	Frank L.	. Jac	kson						Cat	heri	ne Po	nne													
ID 21215-00; should be filed with and Mental Hygiene and Mental Hygiene is marked other. It is marked other. The December 2 Th	2	19a. Informant's Name	e/Relationsh	ip (Type, P	rint) Hus	sband	19b.	Mailing Ad	dress (Str	eet and Nun	nber or Run	al Route Nu	ımber, (City or Town, State	Zip Code)20886											
ore, MD stand 2 sho of Health and If item 27 is	L	Salahudo 20a. Method of Dispos	<u>leen</u>	<u>A.</u> K	areer	n	9	404]	Pensr	nurst	Cou	rt Mo	onto	gomery	Village,M											
0 0 0 =				3 Re	moval from	CLALA	cremato	y or other p	place)		_	26,	206.	Location - City of	Town, State											
.들 은 일 등 등	ŀ	4 Donation 5 27. Signature of Funer	Other Spe	ecify:		30	one	wari Gard e	menic ens	ess of Facility	20.	10	Ma	nassas	, Virginia											
Balt permit. Depart Import		Cot Name of Puller	M	au d	1.200	CARA	50	Loud	doun	Fune	ral (Chape	els	2	0175											
Physician	1	23a. Part Enter the d	disease, or o	omplication	ns that cause	ed the death	. Do not	enter the m	ode of dyin	etin 9, such as c	ardiac of re	espiratory at	lest, sh	ock, or heart	Approximate filterval											
/Medical Examiner		failure. List only of Immediate Cause (Fin		1.1		yline	int	oxica	tion						Death											
Zammer		or condition resulting i	in death)	Due to	(or as a cor	nsequence o	f):																			
		Sequentially list condit if any, leading to imme		b. Due to	(or as a cor	nsequence o	f):	-						.												
ited 1 ansit		cause. Enter Underlyi (Disease or injury that	initiated	c			0:																			
and and transit	1	events resulting in dea	ath) Last	d.	(or as a cor	sequence o	τ):																			
al al	3	X UNPENDED			NDED 7	28a-f,	202	ME at	20/ 6	/9/10	ተ															
68760, certificate be exe	Ĭ,	IF FEMALE:		230	و / کو اغا If yes, outc	ome of preg	nancy	rie g	704 0	70/10	11		23	d. Date of delivery												
	∃ I′	3b. Was decedent pre past 12 months?	egnant in the	1 4	Live birth	at time of de	ath _	Fetal d		Ectopio	pregnancy	y		Month D	ay Year											
Box e death c the attented for us	riiysicia	1 Yes 2 No	9 🗸 Unkr		Unknown		5	Other	(Specify)																	
P.O.		Part II. Other significa	ant condition	ns contri	buting to dea	ath but not re	esulting	in the unde	rlying cause	e given in Pa	ırt I.		_													
S, P. uires the uires the d bed d bed	200											1 Ye	s 2	No 3 Prob	abiy 4 🗹 Unknown											
ords aw requii nas been s 2 should												24a. Was	psy	prior to c												
Rec The la	najajdijioo												ormed? 2 ✓ N	death?	s 2 No											
tal Recipion: The certificate rector, page	ן מ	25. Was case referred examiner?	to medical	Hospita	ŀ					Other4	1															
Division of Vital Records, P.O. lal or Attending Physician: The law requires that the safe death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact best in the funeral director.	٩L	1 Yes 2 27. Manner of Death	No		a. Date of Ir	tient 2 🗸		patient 3	DOA 128c In	jury at Work	Nursing H			ence 6 Other												
ion of tending Pl eath. or: After the funera		1 Natural 5	Pendir		(Month, Day	(Year)		3:00 a		Yes 2	No St	ibject	in	gested m	edication											
risic r Atte ter dea irecto n by th	2	2 Accident 3 X Suicide 6		2	d 5/24 Be. Place of	Injury - At ho	ome, fan					f. Location ((Street a	and Number or Ru	al Route Number, City											
Division of oppiral or Attending hours after death. Increal Director: After y filled in by the fun		4 Homicide	detern		Specify)	ho	ouse				Mo	or Town, ontgon	State 9 1e r y	Village	MD MD											
Fu Flu	- 1 -													nd manner as state												
To the H. within 24 To the F. completel				iner: On th and m	e basis of ex nanne <u>r state</u>	camination and	nd/or inv	estigation,			curred at th	e time, date	_	ace, and due to the												
	• ²	29b. Signature and title	e of certifier							nse number				Date signed (Mor. y 25, 2010	th, Day, Year)											
		tamen))out	hall,	(M)	(de est. / "	00-1		0.0				ivid	y 20, 2010	te, Zip Code 20886 Village, MI or Town, State Virginia Between Onset and Death Obably 4 Unknown autopy findings available completion of cause of											
6		30. Name and address Pamela E. Sou				death (Item dical Exal		111 P	enn Stre	et, Baltim	ore, MD	21201														
Stat	e ⁽	31. Date filed (Month)	Day, Year	2010	32. Regist	rar's Signatu																				
Registra		10	A S	ZUIU	Sins	WAR.	B.	A JOA	Printer of the Printe																	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 19, Olive Jane Long 2010 10:25 p May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Golden Living Center Westminster 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Months Days Hours Min. **Director** 90 July 28, 1919 Washington, DC 216-01-6567 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f sho Director 1 ☐ Yes 2√2 No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1234 Washington Rd. USA 21157 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Bace - American Indian. 11. Marital Status after 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2**X** No 21215-0036 1 ☐ Yes 2 No Specify ≥ Specify: 72 hours 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Store Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other trainmant. Department Manager/Buyer Leggetts Department Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Webster Wiley ဥ Anna A. Willey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Long 21158 1242 Carrollyn Dr. Westminster, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/22/10 Westminster Cemetery Westminster, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Pritts Funeral Home & Chapel, PA 21. Signature of Funeral Service Lige 412 Washington Rd. Westminster, MD 23a. Partie finter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a conse tience of) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician; The law requires that the death certificate be executed and Due to (or as a consequence of) burial attending physician for use as the buria Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No signed by the a o 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 🗆 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Hospital or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. hours after death uneral Director: A 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a

within 24 ho

To the Fune

completely f the WSL 15

State

29a. Certifier

29b. Sign

(Check only one)

are and title of certifie

Registrar

DHMH 17 Rev 1/2001

se of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 12:29 PM owman 20, May 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cecil ElKton Hospita union 5. Social Security Number If Under 1 Ye 8. Date of Birth (Month, Day, 08 | 22 | 1 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 222-32-553 Months 1□ M 2 F Days Hours Min. **Director** Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show "natural", or items 23a or 28a-f shov Director DE New astle 1XYes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? US 2 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Specify. Completed by Specify: White 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) marked other than Elementary/Secondary (0-12) College (1-4or 5+) counting ., Pages 1 and 2 should be file tment of Health and Mental H tant: If item 27 Is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Town, State, Zip Code) Siste New item 27 other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town, State Wilmington, permit, Page Department o Important: If any Injury or = 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery 05/25 4 ☐ Donation 5 ☐ Other (Specify) Feeley Family Funeral 21. Signature of Euneral Service Licensee 22. Name and Address of Ficility Strang + Feeley +0 635 Churchmans 19702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** praten resulting in death) /Medical Due to (or s a consequence f): Examiner Cancer with lung Lesimo Metastate S. Lendolly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐Yes 2 No 1 ☐ Yes 2**"N**0 director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Mnpatient this Certification: To filled in by the funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 28c. Injury at Work? 1 Natural 5 Pending investigation Injury death, 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 69048 MA 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

2 4 2010

tikton

Street

Bow

32. Registrar's Signature

106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day **Physician** 8:29 AM Mar Georgia Loudermill 13 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Laurel Regional Prince taspital Laurel, MD Georges If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 938 Months Days Hours 1 □ M 2 🛛 F Tennessee 509-48-6117 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examination and once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 ☐ Yes 2 XNo Laurel Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20708 9010 Briar Croft Apt 325 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify Specify: Black 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Children World 12th 2yrs Child Care Provider 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be R. J. Wallace Beulah Williams ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Belt(Daughter) 1502 King Phillip Circle Severn, Md. 21144 20a. Method of Disposition 20b. Piles of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5-22-10 Memorial Park Annapolis, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Withame are delissed Facilitisons Mortuary, 821 West St. Annapolis, Md. 21401 13, Keen 1100883 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ventricullar F. brillation 5 minutes Due to (or as a consequence of): Franction Myocardial one hour Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Atherosclerosis Coronary y cork many Due to (or as a consequence of): Physician/Medical Mellitus Itypertension Diabetes and IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Vascular 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☑No 1 ☐Yes 2 No Be (25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☑ No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and the burial-tran Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria filled in by

Physician

/Medical

Baltimore, Maryland 21215-0036

5 ☐ Pending investigation 1 Natural 2 □ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ax 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Medical

7300 Van Dugen

Wang Koon MD

Rd. Laurel, Md. 20707

31. Date filed (Month, Day, ^{Year)} 8 2010 egistrar's Signature

within 24 hours a To the Funeral D

completely

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. STATE Of Maryland Bepartment of Acath and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day Charles L ZOIO 04554M ay Medical 4a. Facility Name (if not institution, give street and number) County of Death **Examiner** Brooke Grove Rehabilitation and Nursing Center Sandy Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 9, 1 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🛣 F Hours Min. Country) Arkansas 441-28-0881 Director 931 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Funeral Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified. 1X Yes 2 ☐ No Montgomery Sandy Spring 10e. Street and Number 10g. Citizen of What Country? 18131 Slade School Rd. 20860 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Yes 2 X No Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Caucasian 3 ★ Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Selman Mary Ethyl Worthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15501 Derwood, Maryland 20855 Keith Ligon Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Crematory 5/26/2010 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland . Signature of Funeral Service Licensee M01463 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lure. List only one cause on each line. 23a. Part / Enter the di shock or heart fall Immediate Cause (Final Approximate Interval Between Onset and Death Physician Alzheimer's disease advanced years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year 1 Yes 2 Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4. Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🎏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier up attending physician and address of person who completed cause of death (Item 23a) (Type, Print) M.D 18100 Stade School Road Sandy Spring Mayland 20860 Grace Brooke Huffman 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death , Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 19. The1ma Lillian Lemon 5:55 P М Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 X F Days Hours June 21 New York 060-32-0989 70 **Director** 1939 Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director notified Maryland Prince George's Brandywine 1 Yes 2 XXNo 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 11908 Lusbys Lane 20613 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0. 1 Yes 2 XXNo
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2xxNo Specify: Black "natural", Completed 3 X Widowed 4 Divorced Specify Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry leath and Mental Hygiene.
n 27 is marked other than "n r traumatic event the (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Colfege (1-4 or 5+) Administrator Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental 8 Important: If item 27 is marked o any injury or other traumatic eve once. ပ Thomas Dewey Stansbury Dorothy Annette Nash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Troy Jonathan Davis / Son 8316 Sunnybrook Court Brandywine, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2XXCremation 3 ☐ Removal from State 5/28/2010 Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Rd. Oxon Hill, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if the stanger of the cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to for as a consultence of the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last the burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 menths? Dav Pregnant at time of death the g Unknown 9 Unknow signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autons death? 1 Yes 2 No Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 2\ Nb မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No ☐ Accident
☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the bes of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 20<u>10</u> Physician/ Geraldine H. Love 20 1:35 May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5819 Goucher Drive Berwyn Heights Prince George's 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sept 28, 1 M 2 X F Hours Director 90 Ohio 276-18-5435 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is an araked other than "natural", or items 23a or 28a-f sho important: If tiem 27 is an araked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d Inside City Limits Director Prince George's Berwyn Heights 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20740 5819 Goucher Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 2 🔀 No Yes Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify: If Yes. Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Librarian McKeldin Library Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur Hoffman Clara Heckler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas J. Love - Son 8711 63rd Ave., Berwyn Heights, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory | 5/22/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician Carcinoma metastatic to lung disease or condition mo Medical resulting in death) Due to (or as a consequence of): Examiner Unknown primary Sequentially list conditions, If any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Directo for as a nonsequence on Examir tran that initiated events Due to (or as a consequence of): resulting in death) Last burialattending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death 2 X No the g Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate ☐ Yes 1 ☐ Yes 2 🕱 No 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 1 🗌 Yes 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this of in by the funeral dir 4 ☐ Nursing Home 5 🛛 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? death. Accident Suicide Investigation 6 Could not be

Funeral I within 2 To the I State Registrar

after

filled in by

Medical

4 - Homicide

29a. Certifier

(Check

29b. Signature and title of certifie

Michael Berard, MD

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

7305 Baltimore Ave., #107, College Park, MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D26287

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

Registrar

28f. Location (Street and Number or Rural Route Number)

29d. Date signed (Month, Day, Year) 5/21/2010

20740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MAY วัติ10 2300 WILSON DAVID LEWIS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOUTHERN MARYLAND HOSPITAL PRINCE GEORGE'S CLINTON . Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Min 1 X M 2 D F Months Hours Director 461-13-9004 Beaumont, Usual Residence of Decedent per mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1.XYes 2 No Maryland Prince George's District Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Completed by Funeral 20747 2504 Overdale Place United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private General Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lonnie Allison Frank Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2504 Overdale Place District Heights, Maryland 20747 <u>Jean Lewis</u> / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ScBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 5/27/2010 Maryland Veterans Cheltenham, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1. Enter the disease. Con plication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ONGESTIVE MEART disease or condition Medical resulting in death) Examiner ARDIOMYO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy 3 🗌 Day Year Pregnant at time of death 5 Other (specify) 4 L Pregnam 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 \square Yes 2 \square No 3 \square Probably 4 \searrow Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy performe page Yes 2 X No 1 🗌 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 No 1 Yes မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) work? s after dec. •al Director: After Natural injury 5 Pending 2 Accident
3 Suicide 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature e of certifier 3885 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) 20735 SURRATTS 7501

Registrar DHMH 17 Rev 7/2009

Box 68760

Division of Vital

10-03750 Zykel Littleton Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Lyker Littleton		Registrar		er f.h g	912 2	rtificate di	Death	and wichte		Reg. N	o. ∠ U	U	110
Physician Medical Examine		Decedent's Name ZYKEI		e,Last) LITTI	ETON				2. Date of Month	f Death Day 5, 2010	y Year		3. Time of Death 1837 hrs
				n, give street and nur	nber)	4		or Location of D			4c. County o		·
Funeral		Prince Geor			7. Age (In yrs.	last birthday)	Cheverly If Under 1 Y	ear If Under 2	4Hrs 8 Date	of Birth (M	Prince G		
Director		NONE		1 M 2 F		Yrs.	Months D			.7,20		Foreign Cour	place (State or MARYLAND ftry)
any	ł	Usual Residence of 10a. State	10b. County		10c. City	, Town or Location	n					- 1	10d. Inside City Limits
Maryland 28a-f show		MD		GEORGE'S	CA:	PITOL HE							1 X Yes 2 No
the Mary is or 28s	DIFECTOR	10e. Street and Nur 1226 BENI		ROAD # 304			10f. Zip Code 20743			USA	itizen of Wh	at Count	ry?
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shoutraumatic event, the Medical Examiner must be notified at once.	runerai	11. Marital Status 1 X Never Marrie	ed 2 Mar	4 4	edent Ever in Urces?		Decedent of l s, specify Cub	Hispanic Origin? pan, Mexican, Pu	(Specify Yes erto Rican, etc	or No-	14. Race White		an Indian, Black,
s after rall", o	출 -	3 Widowed		rced If Yes, Give Year or Dates:		1		No specify:	.6	Lio	Specify:	BLA	
5-0036 ed within 72 hour sygiene. other than "natu		Elementary/Seco		fy only highest grade College (1-		during mo	st of working l	pation (Give kind life. DO NOT use	retired)	166	. Kind of Bus	iness/In	dustry
within within iene.		0				N/A					N/A		
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica		17. Father's Name (CHRISTO)	PHER L	LITTLETON				NINA	ame (First, Mic	RIS	,		
shou shou and h	2	19a. Informant's Nat		ip (Type, Print) TLETON/FA	THER	19b. Mailing (Address (Str BENNIN	reet and Number	or Rural Route #304 C	Number,	City or Town OL HEI	, State, 2 GHTS	Zip Code) , MARYLAND 20743
S 1 E E E		20a. Method of Disp 1 A Burial 2		3 Removal fro	m State	Place of Dispositi	r place)		Date /28/20		Location -		
Baltimore, permit. Pages 1 an Department of He Important: If it injury or other tr	ŀ	4 Denation 5 21 Signature of Fur			150	SURRECT 22. Na			J. B.				
	4		13			74	174 LAI	NDOVER R	OAD LA	NDOVE	R,MARY	LAN	
Physician /Medical		failure. List onl	y one sause or	omplications that can n each line. a. Sudden						ry arrest, s	hock, or hea	rt	Approximate Interval Between Onset and Death
Examiner		or condition resultin		Due to (or as a			.ach 11	THEAR	J				
i de		Sequentially list con if any, leading to im- cause. Enter Under	mediate	b. Due to (or as a c	consequence o	of):							
red Insit		(Disease or injury the events resulting in o	nat initiated	Due to (or as a c	consequence o	of):						-	
760, icate be executed physician and the burial - transit		X UNPENDED		d AMENDED 2.	7 28a-f	per EM	σ 9 Ω/, <i>f</i>	5/28/10	դոր				
68760, ertificate be ding physici e as the buri	2	IF FEMALE: 3b Was decedent p		23c. If yes, or	utcome of preg	nancy	death 3	3 Ectopic pre		2	3d. Date of o	lelivery Da	y Year
Sox leath c	l) sicia	past 12 months?		4 Pregna	nt at time of de	ath _	r (Specify)		gridiloy	- 1	WOTH	Da	y real
P.O. E s that the c gned by the e detached	3	Part II. Other signifi	icant condition	ns contributing to	death but not r	esulting in the un	derlying cause	e given in Part I.			o use contrib		e cause of death?
Division of Vital Records, P.O. ral or attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacled in by the funeral director. Be Completed by Beatacles	ומומו	•								Was an			psy findings available mpletion of cause of
Reco The lav							***		_	performed?	de	ath? ✔ Yes	2 No
rital Residential Recipional The intector, page	3	25. Was case referre examiner?		Hospital:	natient 2	ER/Outpatient	_	Other	eck only one)	Pasic	lanca 6	Other	
ion of Vital tending Physician; eath. for: After this certif the funeral director, ation: To Be of	- 1-	1 Yes 2 27. Manner of Death		28a. Date o		28b. Time of Inju		ijury at Work?	28d. Desc		jury occurre		
ivision or Attendiatter death. Director:		1 Natural 2 Accident	5 Pendin Investig	gation Fd 5/	15/10	5:41 pm	1_	Yes 2 No	unk	i /0tt	and Manhar	- Duna	I Deute Niverbee Oit
Division o Septral or Attending hours after death. uneral Director: Aft y filled in by the fune Centification:		3 Suicide 4 Homicide	6 X Could r	not be	house		ractory, office	building, etc.	Apt or To	34 Ca	1226 E pitol	enn Hei	Route Number City Lng Road ghts, MD
the Ho hin 24 h the Fu				sician: To the best iner:On the basis of	examination a								cause(s)
To To Con		29b. Signature and t	itle of certifier	and manner sta	ted		29c. Licer	nse number		29d	. Date signed	d (Month	n, Day, Year)
		Hustel 9	Veethou	U, MD			0.0	C.M.E.		Ма	ıy 17, 201	0	
	1	30. Name and addre Pamela E. S		ho completed cause Assistant M		•	Penn Stre	et, Baltimore	, MD 2120	1			
State		31. Date filed (Month	Ray (ear)	32. Reg	rar's a griate								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 31, Physician/ 2010 Mabel Louise Lins 12:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6349 Brown Quarry Rd. *Sabillasville* Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min. Aug. 29, Country) Virginia 229-36-6479 78 1931 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Sabillasville Maryland Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō traumatic event, the Medical Examiner must be with 23a Funeral 6349 Brown Quarry Road 21780 U.S.A. items ; 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces Black, White, etc ò Ś 1 Never Married 2 Married ☐ Yes 2💢 No Maryland 21215-0036 1 ☐ Yes 2 🛴 No Specify: If Yes, Give Specify: and Mental Hygiene. is marked other than "natural", Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Seamstress 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) be filed ပ Goldie Wheeler John H. Hudson permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith Elaine Crawford (Daughtet) 25720 Military Rd. Cascade, Maryland 21719 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date June 7, 1 Burial 2 Cremation 3 Removal from State ò Smithsburg, Maryland injury Smithsburg Crematory 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO 1414 12525 Bradbury Ave. Smithsburg, lee Maryland 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical sequence of): Examiner our tielly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown certificate has been signed by the rector, page 2 should be detached P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed' 1 Yes 2 No Yes Division of Vital director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 🗌 Pending 1 Natural injury 1 Yes death Accident Investigation within 24 hours after death

To the Funeral Director:
Completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

State Registrar 30. Name and address of

31. Date filed (Month, Da

GARREN

DHMH 17 Rev 7/2009

MONT ALTO, 14 17237

of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 29^{Day} Month May Physician/ 2010 8:30 A. Bernard Anthony Litchfield, Sr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Adamstown 3203 Hyde Park Court 9. Birthplace (State or Foreign 8. Date of Birth If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min. (Month, Day, Year) 08/12/1918 Country Months 1 ★M 2 □ F Washington. Director 579-09-8328 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County Director 1 ☐ Yes 2√∑ No Adamstown Frederick MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21710 3203 Hyde Park Court Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give within 72 hours after death Black, White, etc. 1 Never Married 2 Married Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 😾 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) self employed and 2 should be filed within 77 Health and Mental Hygiene, tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) heating/cooling owner/operator 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) မ Barbara Antoinette Gaegler Bernard S. Litchfield other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3203 Hyde <u>Park Ct., Adamstown, MD 21710</u> Anna M. Bullard/ former wife of Healt : If item ? 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page 1 Department of Important: If ii any injury or o Smithsburg Crematory 6/1/2010 Smithsburg, MD Signature of Funeral Service License 22. Name and Address of Facility Keeney & Basford Funeral Home 106 E. Church St., Frederick, MD 21701 MO1222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Coronary Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the box Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?

1 Yes 2 No Month 1 Yes 2 g g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Dementic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed; 2 🗌 No Yes 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Defining Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie jone MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 56 Thomas Johnson Drive, Suite 200, Frederick, Maryland 21702 M.D.Amy Jones, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

IIN 0 7 701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 16, 2010 5:43 Ам Donna Mercanti Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year If Under 24 Hrs Age (In vrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1-7-1938 Hours Min. **Director** Washington 536-34-2365 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County Prince Georges 10c. City, Town or Location Bowie 10d. Inside City Limits Director Maryland 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? by Funeral 3616 Majestic Lane 20715 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2x Married ☐ Yes 2 😿 No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Own Home Elementary/Seconday (0-12) College (74 or 5+) <u>Homemaker</u> Be 18. Mother's Name (First, Middle, Maiden Surname)
Margaret I. Mackie 17. Father's Name (First, Middle, Last) NIELS L. ပ္ Larsen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20715 William A. Mercanti 3616 Majestic Ln. Bowie, Md. 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2X Cremation 3 Removal from State Atlantic Crematory 5/18/2010 Glen Burnie, Md 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Robert E Evans Funeral Home 22. Name and Address of Facility 16000 Annapolis Rd. Bowie, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) 0 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 7 10 မ 1 Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7dpL 4175 N. Hanson Court Bowie, MD 20716 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

MAY 182010

1-	For State Registra
1-	State

State of Maryland / Department of Health and Mental Hygiene

		T = State Registrar			Cei	rtificat	e of L	Jeath			Reg.	. No.			
hysicia		1. Decedent's Name (First, Middle,		r -						2. Date of		Day	Year		of Death
mysicia /Medic:		Mira			Donald					May	18,	2010		il	30 AM
Examine		4a. Facility Name (If not institution,										4c. County			
		Gladys Spellman			for a definite alors of		verly	/ If Under	24 Hrs. 1	0.0		Prince			
neral ector		5. Social Security Number 6 234-35-2404	i.Sex 7. 1 ☐ M 2 ဩrF	33	. last birthday) Yrs.	Months		Hours	Min.	8. Date of (Mont) 1/2/	if Birth 1, Day, Yo 1077	ear)	9. Birthp	Virg	or Foreign
CLOI		Usual Residence of Decedent	71							1/2/	19//		west	VILE	шта
		10a. State 10b. County		10c. C	ity, Town or Lo	cation						<u>-</u>	1	0d. Inside	City Limits
onea.	tor	Maryland Prince George Upper Marlboro												1 🗆 Ye	s 2∏No
	Director	10e. Street and Number				10f. Zip	Code				10g	. Citizen of V	Vhat Cour	try?	
	0	10304 Lord Nelso	on St.			207	772					USA	1		
	by Funeral	11. Marital Status	12. Was Decede	ent Ever in U	J.S. 13.	Was Deced	dent of Hi	spanic Ori	igin? (Spe	cify Yes o	r No-		e - Americ		
1	F	1 ☐ Never Married 2 Married		M No	i	ires, sper 1 □ Yes		Specify:		nican, etc	.)		k, White,		
	5	3 Widowed 4 Divorced	Year or Date	es:		10 165	2 <u>00</u> 1NO	эрвспу.				Specify	· Whi	те	
	Completed	15. Decedent's (Specify only highest)	Education grade completed)		16a. Deced	kind of wo	rk don <i>e</i> d	turina mos	st of workin	ng	16	b. Kind of Bu	siness/Ind	dustry	
	ם	Elementary/Secondary (0-12)	College (1-4	or 5+)		DO NOT u									
	ပိ	47 Fathada Nama (Giast Atiddia) a	1		Assis	tant	riana			15:		alMart			
	Be	17. Father's Name (First, Middle, La Rodney Sn	nith									iden Suman	ie)		
	၉						4-1		arie		ncai				
		19a. Informant's Name/Relationship										ity or Town,			
		D. Shane McDonal	.d/Husband	20h	10304 Place of Dispo	Lord	l Nel	son	St. I	Ipper	Mar	1boro,	MD 2	3772	
		1 ☐ Burial 2 🛣 Cremation 3		ate Ka	cometery, cren alas Cr	natory or o	ther place or V	θ)	5/23/			dgewat			nd
		4 Donation 5 Other (Spe					-	1							
		21. Signature Funeral Service Lo	censee /		6	160 C	d Addres	is of Facili TT≛ 1 1	n Geo	rge	P. K	alas F	uner	al Ho	me
		and the second second										1, MD	2074.		-1
		23a. Part 1. Enter the disease, or co shock, or heart failure. List on												Approxim Interval B Onset and	etween
ı		Immediate Cause (Final disease or condition resulting in death) a. Actual Cancing of Enrich With Lung Due to (or as a consequence of):								ng		i. eah			
ı		resulting in dealiny	Due to (or	as a consec	quence of):					mi	िवि	stas +	25	7	
ı	_	Sequentially list conditions, if any, leading to immediate	b. — Due to (or	as a consec									_		
].	듣	cause. Enter Underlying Cause (Disease or injury	1	us u conso	1001100 017.										
1.	Examiner	that initiated events resulting in death) Last	c Due to (or	as a consec	quence of):										
		-													
:	/Medical		d												
1	Š	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco									23d Dat	e of delive	irv	
	cla	in the past 12 months? 1 ☐ Yes 2 ➡ No	1□Live birtl 4□Pregnan			Ectopic pr Other (sp						Мо		Day	Year
	Physician	9 Unknown	9 Unknow				,,								
	by PI	Part II. Other significant conditions	contributing to deat	h but not res	sulting in the ur	nderlying c	ause give	n in Part I		23e.	Did tobac	co use cont	ribute to th	e cause of	f death?
											1 🗌 Yes	2 No	3 🔲 Prob	ably 4	Unknow
1:	Completed									24a. '	Was an	24b. \	Were auto	osy finding	s availab
	Ĕ	· · · · · · · · · · · · · · · · · · ·									autopsy performed es 2	g?	leath?	psy finding npletion of	cause of
	ပိ	25. Was case referred to medical							15 4	-	- 277	No 1	Yes	2 No	
10	0	examiner?	Hospital:	ationt 2	ER/Outpatien	t 3 🗆 DC	Othe		of Death		-	- 6 🗆 0 +	(0 (,	
	2	27. Manner of Death	28a. Date of (Month,		28b. Time of		8c. Injury Work					e 6 Oth		"	
	후	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		Day Year)	Injury	м		? /es 2 ☐				. ,			
	Certification:	3 Suicide 6 Could not	be 28e. Place of	Injury - At h	ome, farm, str	eet, factory	, office		2	28f. Locati	on (Stree	et and Numb	er or Rura	I Route Nu	ımber,
1	ert	4 Homicide determine	building	etc. (Speci	fy)					City o	r Town, S	State)			
		29a. Certifier 1 € Certifying	Physician: To the be	st of my kno	owledge, death	occurred	at the tim	e, date an	nd place, a	and due to	the caus	se(s) and ma	nner as si	ated.	
1	edicai	(Check only 2 Medical Ex	aminer: On the basi and manner	s of examina	ation and/or inv	estigation	, in my op	inion, dea	th occurre	ed at the t	me, date	and place,	and due to	the cause	(s)
1	ž	29b. Signature and title of certifier	11	. /	7		. License					Date signed			
		Ma Olam	levore	me	_		00	18.	52		M	164 18	8,2	010	
1		- Luce our		of dooth (ltm	- 00-\ (T	D : 4			-			,	/	7 40	
		30. Name and address of person wh	o completed cause	л овані нім	n 23ai (Ivne	Printi									
		30. Name and address of person who	FVORK		HZB3 (Type, Hture	Print)	ows	ben	RA	Mis	40	Lui 11	e M	1 20	フと

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 05 2010 p_M 9:45 Lee Moore Medical Mamie 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death 4b. City, Town, or Location of Death Casey House Rockville Montgomery 6. Sex Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 1 🗆 M 2 🔀 F Months Days 07/09/1924 **Director** 719-16-3995 Augusta Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 K Yes 2 No DC Washington ritems 23a or ner must be n ö 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2105 I Street, N.E. 20002 Apt United States Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö þ 1 Never Married 2 Married ☐ Yes 2 🔀 No If Yes, If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Midowed 4 Divorced Completed **Black** the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Private Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Walton Svlvia Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice M. Blake - Daughter 1717 Douglas Street, NE Washington, DC 20018 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 🗶 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Lincoln Cemetery 5/20/2010 Ft. Brentwood, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Ft. Lincoln Funeral Home. 23a. Fart 1 Inter the disea or complete one shock, repeat failure. List only one cause on each line. Brentwood, MD 20722 Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of): Examiner Acute Renal Failure Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year signed by the aid be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4x Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy death? 2 X No Yes To the Hospital or Attending Physician, within 24 hours after death.

To the Funeral Director: After this cartific. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🔀 No Other: မြ 4 Nursing Home 5 Residence 6 Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA : After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury within 24 hours after death.

To the Funeral Director: Al completed filled in by the fu Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month. Day, Year) D0070208 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eliezer Soto, MDMontgomery Hospice 6001 Muncaster Mill Rd Rockville, MD 20855

Registrar

DHMH 17 Rev 7/2009

State

3altimore, Maryland 21215-0036

Box 68760

P.O.

Records.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mary 18, 2010 Physician/ Virginia 6:45p Morgenthaler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) 93 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 365-07-2916 1 🗆 M 2 🗔 Days Hours 6/07/1916 Michigan Director Usual Residence of Deceden 28a-f shov 10a, State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director MD Montgomery Rockville 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code items 23a or 10g, Citizen of What Country? Funeral 17859 Bowie Mill Road 20855 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō 1 ☐ Yes 2 🛣 No If Yes, Give þ 1 Never Married 2 Married Baldimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: "natural", White Completed 3 XWidowed 4 Divorced Specify: Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Music Education Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Hill ည Mamie Spangler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17859 Bowie Mill Road Rockville, Md. 20855 Donald Junker/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other pl Woodlawn Cem. 1 🔀 Burial 2 □ Cremation 3 🖺 Removal from State 6/4/2010 Detroit, Michigan 4 ☐ Donation 5 ☐ Other (Specify) Signatur PHTTPPADESRITALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician End stage dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Parkinson's disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Coronary artery disease 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv death? eral Director: After this certificate filled in by the funeral director, pag 2 **X** No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 2 X No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6 🗷 Other (Specify hospice 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending work' Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 ⊑ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 19,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Diane Ruckert CRNP 600! Muncaster Mill Road Rockville, Md. 20855 31. Date filed (Month, Day, Year) Registrar's Signature State 2010

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 5 / Sertificate of Death Amend #5 per Iform. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lavonda Month Day R. Martin May 20 2010 13:12P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Southern Maryland Hospital PG Clinton If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 06/29/1964 Special Security Number 7 9. Birthplace (State or Foreign Country) **Funeral** Min. Hours Director -9407 Washington Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD PG Brandywine 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 13502 Danielle Court 20613 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married ☐ Yes 2**X** No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", If Yes, Give Specify: Black 3 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) AAS <u>Estate Investor</u> Self Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ernest Smith Rosa Huntley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Randolph Martin/ Husband 13502 Danielle Court; Brandywine, MD 20613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Beltsville, MD 22. Name and Address of FacilitFreeman Funeral Services MD 20748 4594 Beech Road; Temple Hills, mpications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a. Part 1. Enter the disease, or co Immediate Cause (Final Onset and Death Physician/ DOL disease or condition resulting in death) Medical Due to (or a a consequence of): **Examiner** Sequentially list conditions Gayeritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been some the continuous continuous. the burial-trar Due to (or as a consequence of) resulting in death) Last the attending physician thed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Acute accidentation 1 Yes 2 No B B 25. Was ca e referred to medical examiner? funeral director, 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate; 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 May 20, Physician/ McGee Katherine 4:10AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Geroges Manor Care -Largo Largo If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 03/04/1920 579-18-3999 1 ☐ M 2 🛣 F 90 Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Directo Prince Georges Largo Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 Funeral 600 Largo Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married β Yes 2 X No Specify: Black 1 ☐ Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Self 12th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Grant Jackson Kate Winston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kate Awkward/ Neice 8406 Bonny Drive Forestville, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State First Baptist Church of Coolwell Cem. 05/ Coolwell, VA 4 Donation 5 Cther (Specify) /2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 20019 Dunn & Sons 5635 Eads St.NE Washington, DC 1. Ent. r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Cardiopulmumary Failure Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🛣 No Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? S S Diabetic Mellitus Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔼 Unknown Completed Dementia 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy Prepheral Vascular Disease 2 🗌 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred X Natural 5 Pending Accident
Suicide 1 Yes Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State)

State Registrar

To the within 2

Medical

29a. Certifier

(Check

only one 29b. Signature a

PAILURA

BRDIOPULMUNARY

ho completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

gouthern Aue SE #310 Washington De

29c. License number D 51520

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 ĭ8 **JOHN** HEYWARD MCWHIRTER MAY 4:40 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 7431 CRANE PLACE LANDOVER PRINCE GEORGE'S Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** Hours 1 X M 2 D F Months Days Min. JUNE 25 SOUTH CAROLINA Director 247-32-1915 84 Usual Residence of Decedent d Mental Hygiene. marked other than "natural", or items 23a or 28a-f shov matic event, the Medical Examiner must be notified at 10b. County the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No. MD PRINCE GEORGE'S LANDOVER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7431 CRANE PLACE 20785 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married \$ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: BLACK If Yes Give 3 Widowed 4 Divorced Specify: Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9TH RECEIVING CLERK GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ LEE MCWHIRTER ESTELLE MCGRIFF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 MATEENAH MCWHIRTER/WIFE 7431 CRANE PLACE LANDOVER, MARYLAND 20785 Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 permit. Page 1 Department of I Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State FT. LÍNCOLN CEMETERY 5/24/2010 4 Donation 5 Other (Specify) BRENTWOOD, MARYLAND 21. Signature of Foneral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician ATHEROSCLEROTIC HEART DISEASE Medical resulting in death) Due to (or as a consequence of): Examiner ALZHEIMER S DISEASE Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami Cause (Disease or linjury that initiated events resulting in death) Last and-trair Due to (or as a consequence of) attending physician for use as the burial Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1. Yes 2 No Pregnant at time of death Month Day Year signed by the a g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Hospital or Attending Physician: The law cate has autopsy performe this certificate 1 ☐ Yes 2 🔀 No Yes 2 K No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 X No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending (Month, Day, Year) 1 X Natural injury M 1 Yes 2 No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
Medical Examiner: On the basis of examination and/of in estigation, in my opinion, death occurred at the time, date and place, and due to the caus 29a. Certifier Medical Examiner: On the basis of examination and/o (Check estigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the best of my know eda death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29h Signature

nd title of

WILLIAM R.

30. Name and address of person who

MAY 2 5 2010

31. Date filed (Month, Day, Year)

32. Registrar's Signature S. Sarki

cause of death (Item 23a) (Type, Print)

D07970

FREDERICK M.D. 106 IRVING STREET N.W. #304 WASHINGTON, DC 20010

_29d. Date signed (Month, Day, Year) MAY 20, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yea **Physician** Meredon 1123AM bolmes 26 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, April 19, Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**X** M 2□ F 95 Maryland Director 216-14-5352 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any liny or other traumatic event, the Modical Eraninas mass 1. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Maryland Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21758 United States 205 Saint Luke's Circle, #714 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 X No Specify Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Banking 11 Banker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Blanche Williams Jacob H. Mackley ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 423 1/2 Fast Patrick Street, Frederick, Maryland 21701 Eugene D. Young / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory May 29, 2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney and Basford PA Funeral Home 21. Signature of Funeral Service Licensee M01473 106 Fast Church Street, Frederick, Maryland 21701 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Preumaria atera Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cautions in death), act Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the cleath certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by di (earl arter 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy performe perfen 5,00 1 □ Yes 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2-1No Certification: To After this funeral 27. Manual of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation ours after death.

ieral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours e Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 hound To the Fune completely file Medical and manner stated. 29b. Signature and title of certifig 9c. License number D19T02 MN

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32.

MD

legistrar's Signature

Hosain

2

31. Date filed (Month, Day, Year)

East Main street wethinder MD 2005

4

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

IN U D

32. Registrar's Signature

Jugan.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2016 310 Ressie Mae Nesbit Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Doctor's Hospital Prince George Lanham 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** 1 □ M 2**X** F Months Days Hours Min. (Month, 254-30-5432 Director 84 Georgia Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a. State 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George 1 X Yes 2 □ No Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7013 Hasting Drive 20743 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 X Widowed 4 □ Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance 12th University of Penn Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Watts Gilbert</u> Sadie (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Montue (Daughter) 7013 Hasting Drive Capital Heights Md 20743 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State 1 🛱 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Harmony Mem Park | May21,2010 Landover Maryland 21. Signature of Femeral Service Licer 22. Name and Address of Facility 20011 Tyrone J. Young 719 Kennedy St. NW WashDC 23a. Part 1. Engr the disease, or cor shock, or leart failure. List only that caused the death. on each line. to not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cadse (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Lua to (or sela conesquarios or): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral intensity page 2 should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit attending physician and I for use as the burial-transif Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown NEUMONIA Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29d. Date signed (Month, Day, Year) 05-14-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8118 ERFAN 600 Nham State

ORIGINAL

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 20 2010 BILLY JOE NORMAN 4:14 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER **BETHESDA** MONTGOMERY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year March 5, I **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🖾 M 2 🗆 F Months Days Hours Min. WalnutGrove, MS Director Yrs. 587-07-9015 63 1947 Usual Residence of Decedent shov 10a. State 10b. County at filed within 72 hours after death with the Maryland Director 10c. City, Town or Location 10d, Inside City Limits or 28a-f sh notified 1X Yes 2 ☐ No Maryland Prince George's Cheltenham ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or Funeral 10805 Blackstone Ave., UNITED 20623 STATES items 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Armed Forces? Black, White, etc. ō ģ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify. "natural" 3 Widowed 4 Divorced Specify: BLACK Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 +2 FIRE CHIEF-Retired Government traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ pe MITTIES SMITH WILLIE NORMAN t. Page 1 and 2 should by thent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) В. NORMAN- WIFE GENNIE 10805 Blackstone Ave., Cheltenham, MD. 20623 other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 😾 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or once. 9 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND VETERANS June 1, 2010Cheltenham, Maryland 21. Signature of Funeral Service Licensee MARYLAND, 2074 22. Name and Address of Facility Karle Pope Funeral Home, PA. 5538 Marlboro Pike, Forestvill 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ehysician/ METASTATIC PROSTATE CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) cal Division of Vital Records, P.O. Box 68760 Physician/Medi IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Month Year 2 No 1 Yes 2 L 9 Unknown Unknown has been signed by e 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate har funeral director, page performed' Yes 2 X No 1 ☐ Yes 2 🕱 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 ☐ Yes 2 🙀 No Other: ျ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pendina work' neral Director: A Accident Investigation 1 ☐ Yes 2 ☐ No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined , Ho. , in 24 hours, oo the Funeral Dicompleted filler Medical 29a. Certifie 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) ertifying Nurse Pragitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and of certifie ,2010 5101018528 (MI) and address of person who completed cause of death (Item 23a) (Type, Print) NATIONAL NAVAL MEDICAL CENTER STEVEN F. LT SHELDEN MCUSN

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

BETHESDA MD 20889-5600

0-03968 Folahan Oladei	nde	Clate of Maryland / Bepa				gible. 2010	771				
		Registrar	rtificate of Death			g. No.	1 1 1				
Physici Medical Exam			Oladeinde		2. Date of Deat Month May 24, 20	Day Year	3. Time of Death 1248 hrs				
		Facility Name (if not institution, give street and number) Shady Grove Adventist Hospital	4b. City, Town, or Rockville	Location of Death		4c. County of Deat Montgomery	n				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. Ia 577-98-2385 1 M 2 F 34	ast birthday) If Under 1 Year Months Days			h(MM/DD/YYYY) 9. Bi Forei	thplace (State or gn Washingto buntry) DC				
and show any nce.	ا ا	MD D C	Town or Location				10d. Inside City Limits				
ith the Maryland 23a or 28a-f sho notified at once.	I Director		10f. Zip Code 20735		10	g. Citizen of What Cou USA	ntry?				
fter death w 1", or items	by Funeral	11. Marital Status 1 Never Married 2 Married 2 Married 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No 11 Yes, Give Year Or Dates:	If Yes, specify Cuban	n, Mexican, Puerto	Ricán, etc.)	White, etc. Specify: B1	ican Indian, Black, ack				
61 3 🗖	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2+	16a. Decedent's Usual Occupat during most of working life.	. DO NOT use reti		16b. Kind of Business/	·				
5-003(led within Hygiene. other tha	Com	17. Father's Name (First, Middle, Last)	Constructio	18.Mother's Name	(First, Middle, M	Private					
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Folusho F. Oladeinde		Fannie		James					
imore, MD 2121. Pages I and 2 should be fi ment of Health and Mental tant: If item 27 is marked or other traumatic event,	J.	19a. Informant's Name/Relationship (Type, Print) Folusho F. Oladeinde/ Father	19b. Mailing Address (Street 611 Vista Ter								
re, h l and l Health fitem		20a. Method of Disposition	Place of Disposition (Name of cen	netery,	Date	20c. Location - City or	Town, State				
Baltimore, permit. Pages I an Department of Hea Important: If ite		1 X Burial 2 Cremation 3 Removal from State Rest	urrection Cemet								
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Montal H Important: If item 27 is marked of injury or other traumatic event, til		21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. Jenkins Funeral 7474 Landover Rd., Landover, MD 20									
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Cocaine intoxication									
January 18		or condition resulting in death) Due to (or as a consequence of):									
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause):								
executed ian and ial - transit	al Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of).): 								
760, ficate be exe g physician a	edical	☐ AMENDED ☐ AMENDED 23a,27,28a-f,p	oer ME g905 7/2	2/10 TT							
Sox 68 leath certil e attending for use as	ysician/Med	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 2 No 9 Unknown 9 Unknown	2 Fetal death 3	Ectopic pregnat	ncy	23d. Date of delivery Month	⁄ ∂ay Year				
i, P.O. Baires that the designed by the	by Phy	Part II. Other significant conditions contributing to death but not res	sulting in the underlying cause gi	iven in Part I.		pacco use contribute to					
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Completed				24a. Was ar autopsy perform	y prior to oned? death?	topsy findings available ompletion of cause of				
Vital Rec ysician: The his certificate director, page	BeC	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 V F		of Death (Check o							
of Vi ing Physi After this funeral dir	ျ	27 Manner of Death 28a. Date of Injury 2				esidence 6 Other					
ion (tending eath.	ation	1 Natural 5 Pending 5 / 2 / / 2010			unk	. ,					
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director:	Certification:	3 Suicide 6 X Could not be determined (Specify) oth	me, farm, street, factory, office bu	uilding, etc.	28f. Location (Sti or Town, Sta North Po	reet and Number or Ru hte) 14644 Dev Ditomac, MD	ral Route Number, City Vereaux Ter				
To the Hos within 24 h To the Fun completely	Medical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge one) 2 Medical Examiner: On the basis of examination and									
F. 3 F. 3	¥ e	29b. Signature and title of certifier	29c. License	number		29d. Date signed (Mor	th, Day, Year)				
		pull of my	O.C.N	Л.Е. 		May 27, 2010					
_		30. Name and address of person who completed cause of death (Item 2 Russell Alexander MD. Assistant Medical Examir	iner 111 Penn Street, I	Baltimore, MD	21201						
St Regist	ate	31. Date from Pay Year S. 32. Registrar's Signature	all								
Kegisi	للثقد										

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 May A Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 24 Wardour Dr. Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗙 M 2 🗆 F Months Hours (Month, Day, Year) 449-56-5885 **Director** Oklahoma ofom her Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Annapolis Maryland Anne Arundel 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? USA 24 Wardour Drive 21401 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian Armed Forces Black, White, etc Completed by 1 Never Married 2 X Married Yes Yes, Give 2 No Maryland 21215-0036 White 1 Yes 2 X No Specify: 3 Divorced 4 Divorced 59 - 88Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) US Naval Officer US Navy Be 18. Mother's Name (First, Middle, Maiden Surname)
Margaret Sanders 17. Father's Name (First, Middle, Last) ည James Albert Osburn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Wardour Drive, Annapolis, MD 21401 Linda Osburn - Wife Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 5/17/2010 Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Duke of Gloucester St, Annapolis MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ logenous disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tranthat initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Yes 2 No 4 ☐ Pregnant 1 ☐ Yes 2 L 9 ☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy Plejura ☐ Yes To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending injury work? 1 🗌 Yes Accident Investigation Suicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical 29a Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Frectioner To the basis of exponential and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Frectioner To the basis of exponential and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Frectioner To the basis of exponential and or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mo State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

?	0	1	f	1	7	2	-
mark-d	-	è		1	1	£-	1

		1- For State Registrar		Certifi	cate of	Death			Reg. N	0.	. 0	S S how to
Physici		1. Decedent's Name (First, Midd	lle,Last)					2. Date of D	eath			3. Time of Death
Medical Exam	iner	DEBBIE JEAN P	ETERSON					Month May 10	Month Day Year May 10, 2010			1500 hrs
		4a. Facility Name (if not institution	· =	ımber)	4	b. City, Town, or I	Location of Dea		4c. County of Death			
, , , ,		Prince George's Hosp	oital Center			Cheverly				eorge	's	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. last b	irthday)	If Under 1 Year	If Under 24H	rs. 8. Date of	Birth (M	M/DD/YYYY)	9. Birtt	pplace (State or
Director		579-84-7476	1 M 2 F	53	Yrs.	Months Days	Hours Mi		/105			Washington
		Usual Residence of Decedent	X	53				4/17	/195	/		DC
any		10a. State 10b. County		10c. City, Tow	n or Location	n						10d. Inside City Limits
nd how	_	Manual and 1 Park									- 1	1 X Yes 2 No
arylau 8a-f s	cto	Maryland Prince 10e. Street and Number	e George's	s I Uppe	r Mar	10f, Zip Code			10a C	itizen of Wha		
ith the Maryland 23a or 28a-f show notified at once,	ire	115(5 D -1 :	D .						_			•
ith th	Funeral Director	11565 Dunloring			1.2.11	20774				ted St		
death w	ner		arried Armed Fo	edent Ever in U.S. orces?	13, Was	Decedent of Hisp s, specify Cuban,	oanic Origin? (& Mexican, Puert	Specify Yes or or Rican, etc.)	No-	14. Race - White,		an Indian, Black,
or de		3 Widowed 4 Div	1 Yes	2 X No	, [,	, a 📆						
rs aff ural'	ð	15. Decedent's Education (Spe	or Dates:			Yes 2 X No	1111				B1ac	
2 hours afte	Completed	Elementary/Secondary (0-12)	College (1		during mos	s Usual Occupations of working life.	on (Give kind of DO NOT use re	work done tired)	16b.	Kind of Bus	ness/In	dustry
36 oin 7, than dical	ed	, , ,										
21215-0036 uld be filed within 7 Mental Hygiene, marked other than	E	12 17. Father's Name (First, Middle,	6	Co	<u>nsult</u>		0.84-111-81		G	overn	nent	
The Hy	Bec		•				8.Mother's Nam	, ,		,		
2121 uld be fi Mental I marked	OB	James A. Peter 19a. Informant's Name/Relations	SON		Ole Marillan	W (S)	Villia J	Tackie	Mob1	ey		
MD 2121 (d 2 should be fill the na 77 is marked numatic event, to man the na 77 is marked numatic event, to manage event, to	-1			1.7		Address (Street						· ·
를 마음 등		Willia Jackson 20a. Method of Disposition	Peterson		of Dispositi	Dunlorin	ng Drive	Upper Date	Mar	1boro	<u>MD</u>	20774
Baltimore, permit. Pages 1 at Department of He important: If ite	- 1	1 X Burial 2 Cremation	3 Removal fro	om State crema	atory or othe		etery,	Date	20c.	Location - C	ity or T	own, State
Pag Pag		4 Donation 5 Other Sp		ľ	ngton	Nationa	1 5/1	9/2010	٥	uitlar	he	Maryland
Balt permit. Departs Import		21. Signature of Funeral Service	Licerdee		22. Na	me and Address of	of Facility Por	e Fune	ra1	Homes	p	Δ
E.E.D.& CO		Will Ci	Jan 1	M01085	1.553	8 Maribo	ro Pike	Fores	t 37 i 1	1 a M :	7777	and 20747
Physician		23a. Part I. Enter the disease, or failure. List only one cause	complications that ca	aused the death. Do r	ot enter the	mode of dying, s	uch as cardiac	or respiratory a	rrest, sh	ock, or hear	1	Approximate Interval
/Medical Examiner		Immediate Cause (Final disease		ation with	n comp	lication	ns					Between Onset and Death
Exammer		or condition resulting in death)		consequence of):				_			\dashv	
		Sequentially list conditions,	b									
	Examiner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of):	-							
	Ē	(Disease or injury that initiated	C. Due to /or as a	consequence of):							-4	
ted J ansit	Ш	events resulting in death) Last	d.	consequence or).								
3760, ficate be executed g physician and sthe burial - transit	/Medical	X UNPENDED	7 								\dashv	
e be ysicia	힣			a,27, per	ME G9	08 10/8	/10 TT					
8760, ifficate be up physici		IF FEMALE: 3b. Was decedent pregnant in the	I 23C, If ves. o	utcome of pregnancy			Ectopic pregna		23	d. Date of de		
ox 687 eath certifu	lä.	past 12 months?		and not time and allowed		deatn ɔ (Specify)]Ectopic pregna	ancy	1	Month	Day	y Year
Box 68 te death certi the attending	Physicia	1 Yes 2 No 9 V Unk			Ulliei	(Specify)						
at the lache		Part II. Other significant condition	ons contributing to	death but not resultin	g in the und	erlying cause give	en in Part I.	23e. Did	tobacco	use contribu	te to the	e cause of death?
tal Records, P.O. Box 68 trian: The law requires that the death certificate has been signed by the attending ector, page 2 should be detached for use as	à							1 🗆 Y	es 2	No 3	Probat	oly 4 🗸 Unknown
ds, equii een s	Completed					-		24a. Wa				psy findings available
COI law has t	힘							auto	psy ormed?	pric		npletion of cause of
tal Recision: The certificate ector, page	ခွဲြ							1 ✓ Yes			Yes	2 No
tal certif ector,	Be	25. Was case referred to medical examiner?				26.Place of	Death (Check	only one)				
Division of Vital Records, P.O. ta or Attending Physician: The law requires that th as after death. 'al Director. After this certificate has been signed by led in by the funeral director, page 2 should be detach	잍	1 ✓ Yes 2 No	Hospital: 1 In	patient 2 🗸 ER/O	utpatient 3	DOA O	her Mursin	g Home 5	Reside	ence 6	Other:	1,
fing Ph After t		27. Manner of Death 1 Natural 5 Death	28a. Date o	f Injury 28b. Day,Year)	Time of Inju	ry 28c. Injury a	at Work?	28d. Describe	how inju	ury occurred		
io frend for tor	: 달	Penal	ng igation			1 Yes	3 2 No					
Visio or Atten after deat Director, in by the	읡			of Injury - At home, fa	arm, street, f	actory, office buil	ding, etc.			nd Number o	or Rural	Route Number, City
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use an	Certification:	4 Homicide determ						or Town,	State)			
the Hospita hin 24 hours the Funeral		29a. Certifier 1 Certifying Phy	sician: To the best	of my knowledge, dea	ath occurred	at the time, date	and place, and	due to the cau	ise(s) an	d manner as	stated.	
To the Howithin 24 k To the Function	Medical	one) 2 Medical Exam	iner:On the basis of	examination and/or in	nvestigation	, in my opinion, d	eath occurred a	t the time, date	and pla	ice, and due	to the c	:ause(s)
H 3 F 8	₹ 2	9b. Signature and title of certifier	and manner sta	nou.		29c. License n	umber		29d. I	Date signed	(Month	, Day, Year)
		1/1 71	11			O.C.M.	E. OGM	F	1	11, 2010		
	H	0. Name and address of person v	the complete	of death (Item 23a)	Δ.					, =		
		Theodore M. King, Jr.,	- 11	it Medical Exam	iner 11	1 Penn Stree	et. Baltimore	. MD 2120	1			
Sta	te 3						,	., 2 120				
Registr	ar	1. Date filed (Manth Day Year)	Cenera	istrant Signature								
			, 									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ^{Day} 2010 Blanche Antoinette Poisson 10:30 Рм May 16 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Crescent Cities Center Riverdale Prince George's 8. Date of Birth
(Month, Day, Year)
Sentember 20,1922 Lewiston, Maine Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Days 1 ☐ M 2 🖾 F Months Hours 007-14-3730 87 Director Yrs Usual Residence of Decedent 10b. County 10a, State with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 ☐ No Maryland Prince George's Hyattsville ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı Funeral 3819 Oglethorpe Street 20781 USA death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural" 3 X Widowed 4 Divorced Specify: Completed Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry ગક filed win. ⁴થ Hygiene. `er than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the C & P Telephone Co. Should be filed with and Mental Hygien. I is marked other th 12 Telephone Operator Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Wilfred Bussiere Mabel Provencher traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Robert R. Poisson / Son 3819 Oglethorpe Street, Hyattsville, MD 20781 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 5/20/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery yure of Furneral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Multiple Deep Venous Thrombosis Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions, if any, leaving to introduct cause. Enter Underlying Due to (or as a cur sequence of, Exam that the death certificate be executed Cause (Disease or iinjury Dementia and -trar that initiated event Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires Intraabdominal Hematoma Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension page 2 s has performed? Yes 2 No certificate 1 Yes Division of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🛛 No ij မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this s after death.

I Director: After this id in by the funeral di 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours af To the Funeral Di completed filled in Hospital Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within To the only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63978 5/19/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hina Syed, 7525 Greenway Center Drive, Greenbelt, MD 20770 32. Registra 's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EDWARD I. PONDE 2010 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Montgomery Takoma Park 8. Date of Birth (Month, Day, Year) Aug. 6, 1960 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months 1 🛛 M 2 🗆 F Hours Director 218-82-7546 49 Aug. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or item. any injury or other trainmet: 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20011 United States # 1 Milmarson Place NW Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. ð 1 Never Married 2 Married Black 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Claims Adjuster Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Geneva Myers Edward I. Pondexter, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 221 McGuckin Street Chester, Md. Kirstin Pondexter/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)

Lee's Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 20, May 4 Donation 5 Other (Specify) Clinton, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sign ure of ral Service 4001 Benning Rd. NE Washington, DC 23a. Par 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ wotory disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ... Ectopic pregnancy in the past 12 months?
1 Yes 2 No sate has been signed by the atte page 2 should be detached for a Day 5 Other (specify) Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed hours after death.

uneral Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 ... 29b. Signature മറ്റ് title of certifier 29d. Date signed (Month, Day, Year) rasach Uler, D0063703 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABYASACH UPR

Registrar

State

Date filed (Month, Day, Year)

MAY 2 n 2010

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	Plea	a se Type o State		and / De	partmen	t of H	lealth a		_		_	le.	17700
Physicia Medic		Registrar 1. Decedent's Nam Arnold B		,		<u> </u>	ertificate	OTL	<i>Death</i>		2. Date of Do			ar	3. Time of Death 310am M
Examin		4a. Facility Name (if 1204 Gre 5. Social Security N	en Holi	ly Dr.	,			Ann	Location o	S			c. County of [Anne	Aru	
Funeral Director ≥		219-38-3 Usual Residence of	655	6. Sex 1 🐹 M 2 🗆 F		rs. last birthday	Months	Days	If Under Hours	Min.	8. Date of Bi (Month, D 5/4/		9.	Birthpl Counti	ace (State or Foreign NY NY
th with the Maryland ms 23a or 28a-f show must be notified at	Director	10a. State MD 10e. Street and Nur		a Arundel		. City, Town or			apoli	s					0d. Inside City Limits 1 ☐ Yes ※※ No
ath with the	Funeral [1204 Gre		<u> </u>	cedent Ever in	118 119	10f. Zip	21	409	nin? (Sne	cify Yes or No		USA		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Marr	4 Divorced	ried Armed F 1 X Yes If Yes, G Year or	Forces? s 2 \(\sigma\) No \(\bar{V}\) live	'ietnam	If Yes, spec	ify Cuba 2 🔀 No	n, Mexican Specify:	, Puerto	Rican, etc.)		14. Race - A Black, V Specify:	Vhite, e	
within 72 ho giene. er than "nai , the Medica	Completed	(Special Section (Speci	cify only highe	nt's Education est grade complete College	d) (1-4 or 5+)	I (Giv	cedent's Usua re kind of wor DO NOT use Barte:	k done d retired)	ation <i>luring most</i>	of worki	ng		Kind of Busin Restau		·
ld be filed Mental Hy arked oth atic event	To Be	17. Father's Name (Nicholas		,							e (First, Middle Lette D				
ind 2 shou lealth and im 27 is m		19a. Informant's Na	e P. Q			1204	4 Gree	n Ho			l Route Numb Annapo				
t. Page 1 a tment of H rtant: If ite ijury or oth		4 Donation	Cremation 5 Other (S		m State	tlantio	ematory or o	ther place ator	y	5/18)/2010		ocation - City en Bur		
permi Depa Impo any in		21. Signature of Fu	2.6	J-			22. Name an	gely	Ave.	An	desty napoli	s, M		1	
Physician/ Medical		23a. Part 1. Enter t shock, or hea Immediate Cause (disease or condition resulting in death)	rt failure. List o Final	only one cause on a	caused the deach line.	aest	WL .	Hee	ut.	F	uhir	e L			Approximate Interval Between Onset and Death
Examiner	iner	Sequentially list co if any, leading to in cause. Enter Unde	inditions, imediate	b. Due to	Cor (or as a cons	Onari sequence of):	y An	ter	4	Dis	euse				1 year
oe executed ician and ourial-transit	al Examiner	Cause (Disease or that initiated event- resulting in death)	iinjury s	c. Due to	o (or as a cons	sequence of):									
requires that the death certificate be exbeen signed by the attending physician should be detached for use as the burial	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent	pregnant		utcome of pre								23d. Date of	f deliver	v
the death by the atter ached for u	hysicia	in the past 12 r 1 Yes 2 1 9 Unknown	months?	4 □ Pre 9 □ Un	egnant at time known		Other (sp	ecify)					Month		Day Year
quires that en signed ould be det	ted by	Part II. Other signif	icant condition	ons contributing to	death but not	resulting in the	e underlying o	ause giv	en in Part I						e cause of death?
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial directors.											24a. Was auto perfi 1 \(\sum \text{Yes}\)	psy ormed?	prior deat	to com h?	sy findings available apletion of cause of
nysician is certifi director	To Be	25. Was case referre examiner? 1 Yes 2	No Medical	Hospital:	Inpatient 2	☐ ER/Outpat	ient 3 🗆 DC	Othe	r: 4 🗌 Nu		only one) me 5 X Resi	idence (6 ☐ Other (S	pecify)	
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Certificate:	27. Manner of Death 1 X Natural 2 ☐ Accident 3 ☐ Suicide	n 5 □ Pendir Investi 6 □ Could	ng (Mo	e of injury nth, Day, Year		М				28d. Describe	how inju	ry occurred		
pital or At		4 Homicide	determ	ined 28e. Plac build	ding, etc. (Spe						City or To	wn, State	e) 		Route Number,
o the Hosi ithin 24 ho o the Fune	Medical	(Check 2	☐ Medical E	Nurse Practione	asis of examina	ation and/or inve	estigation, in r e, death occur	ny opinio	n, death oc time, date	curred at	the time, date	and place re cause	e, and due to t	the caus r as stat	se(s) and manner stated ted.
717		30. Name and addre	W	666	MI)		,	63	54		5	117	/2	010
State	e	E W Ce 31. Date filed (Monta	IE;	ST AGA	IFS	am 1	ATDI	VA	VE	BF	LTIM	ORI	E di	D	21229
Registra	-		MAY 1	8 2010	Genera	onature	par	_							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20°10 May Morris Pindell 1318 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 5x M 2 □ Months Hours April 216-36-2743 Director 71 Maryland 1939 Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Mary1and Anne Arundel **Annapolis** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 224 Gross Avenue 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 √ No Specify: 3 X Widowed 4 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other tl 12th Press Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ Morris Pindell Mary E. Galloway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marita N. Pindell (Daughter) 224 Gross Ave. Annapolis, Md. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Bestgate Mem. Park 5/22/10 4 ☐ Donation 5 ☐ Other (Specify) Annapolis, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sons Mortuary Annapolis, M Reese & West St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory rest, shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury squaritially list conditions, Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death Month Day Year as been signed by the a Linknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 █ No 3 ☐ Probably 4 ☐ Unknown 24b Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page performed Yes 2 No 1 Yes 2 No 25. Was case referred to dical examiner? Be 26. Place of Death (Check only one) 2 200 Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify,} \) 1 🗌 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Investigation completed filled in by the Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or invariant and the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and tiple of certifier 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00

State Registrar <u>William Behrens</u>

Annapolis

Md

2448 Hollv

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death May 17, Physician/ 2010 20:40 Рм Donald Clinton Proctor Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Clinton Prince George's Southern Maryland Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Feb. 23, Year 948 DC 62 Director 216-50-6258 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fitein 27 is marked other than "natural", or item marked other than "natural", or other trainmetic. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Director Suitland 1 X Yes 2 ☐ No Prince George's Maryland 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral 2010 Spaulding Avenue 20746 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 Married þ **Black** 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed Laborer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Hilda L. Proctor John W. Proctor, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3001 S. 24th Street Arlington, VA Detra Proctor/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Mayo 21, 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, Maryland 21. Sign 2. Name and Address of Facility Stewart Funeral Home, Inc. 20019 Washington, DC Benning Rd. NE23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Cerebrovascular disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to for as a consequence of if any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) the signed by the detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Hypertension urgency 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed within 24 hours after deatn.

To the Funeral Director: After this certificate I Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 5 🗀 Pending Natural Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 05 Z 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2010 Claudia Ann Phaup 31 May 0340 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Towson Gilchrist Hospice Care Center Baltimore 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days New York 1 □ M 2 X F Hours July 18, 1972 Director 105-50-4364 37 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Frederick Frederick 10f, Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Completed by Funeral 21704 9423 Prospect Hill Place United States Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕅 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", White 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Marketing Professional Retail Food Stores Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Maria Marcotrigiano Anthony Ceci and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Travis Phaup / Husband 9423 Prospect Hill Place, Frederick, MD 21704 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June 5, 2010 permit. Page 1 s
Department of F
Important: If ite
any injury or ott 1 Disputation 3 Removal from State St. John's Cemetery 4 Donation 5 Other (Specify) Frederick, Maryland 21. Signatur of Juneral Service Licensee Keeney and Basford PA Funeral Home Church Street. Frederick, Maryland 21701 106 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician HOBERSTOMA PRIL 2009 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): thany leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year Pregnant at time of death Yes 2 No ate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 X No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 29a Certifier 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 064395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NCHARLES ST, 8417E 4105 BALTIMEREIMS 21204

Registrar DHMH 17 Rev 7/2009

State

6701

32. Registrar's Signature

MO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** 2:10 A M MAY 2010 JERRY LEE PRICE SR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CIVISTA MEDICALCENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 → M 2 □ F Hours JUNE 18,1935 WASH.,DC. Director 578-44-4175 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2X No Director MD CHARLES LA PLATA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10090 CHARLES STREET 20646 U. S. Α. 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE <u></u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) GENERAL SERVICES ADM STEAM FITTER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOSEPH LEVI PRICE AGNES NORMAN ೭ and l 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any njury or other traun once. 10090 CHARLES STREET LA PLATA, MD 20646 WIFE PATRICIA E. PRICE / Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State METRO. CREMATORY MAY 31,2010 ALEXANDRIA, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility RAYMOND FUNL SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 21. Signature of Funeral Service Licensee M00641 ert.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Circhosis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-trans Due to (or as a consequence of): 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) cate has been signed by the page 2 should be detached Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was *a*n autopsy performed Hospital or Attending Physician: The 2 🗆 No 1 Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 □ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print) 201 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

RRY

W

5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #23A, 25, 27, 28A-F, PER ME, C950, 4-30-14, SM
State of Maryland / Department of Health and Mental Hygiene
AMEND PT. II, PER ME, C951, 5-2-14, SM
Reg. No. | | | 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Stanley Curtis Rice P^{M} May 14. 2010 6:36 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Oct. 7, **Funeral** Months Days Hours 1 M 2 □ F 84 Director 407-28-7654 KY 1925 Usual Residence of Decedent 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits Westminster MD Carroll 1 ☐ Yes 2 ☑ No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? If item 27 is marked other than "natural", or items 23a or or other traumatic event, the "badical Examiner must be r 134 Smith Ave. 21157 U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or itee 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2€ No Specify: White Snecify: 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman Bethlehem Steel 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grace Frazier 2 Curtis Rice 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11676 Blue Mountain Dr., Waynesboro, PA 17268 Keith Rice - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Deer Park Cemetery 5/19/2010 Westminster, MD uneral Service 22. Name and Address of Facility Pritts Funeral Home & Chapel, P.A. 21. Signatur 412 Washington Rd., Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the man of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician AORTODUODENAL FISTULA TEAR /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): CERTIFIC THOM APPROVED BY MEDICAL EX burial-trar death certificate be execu Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, GASTRIC ULCER, EMPHYSEMA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ATHEROSCLEROTIC CARDIOVACSULAR DISEASE 24a. Was an page 2 autopsy certificate 1 Pres 2 □ No 1 PYes 2 No 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To spital or Attending Pl ours after death. neral Director: After t 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred SUBJECT WAS THE DRIVER OF A CAR THAT STRUCK AN ELECTRICAL UTILITY POLE 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 Natural 5 Pending investigation **P** M 1 ☐ Yes 2 XNo 2 X Accident 5-13-2010 2:31 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) 560 GORSUCH RD. WESTMINSTER, MD. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ROADWAY Hospital 624 hours a e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hou To the Funer completely fil Medical and manner stated. 29b. Signature and title of certifier WJL 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) 10 200 Memorial Ave., Westminster, MD 21157 Enrico Giangeruso, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar B. parker

DHMH 17 Rev 1/2001

Registrar DHMH 17 Rev 1/2001

肾坏 2010 21045 MO-

State

MB VELLANKI, 31. Date filed (Month, Day, Year)

32. Registral's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NB VELLANCE, 8850, Co (Lembre 100 (Vernew)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For AMEND#5 per FH State
Registra AACO HEALTH DEPT. 5/27/10 CMH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carolyn Keyeur Month 12:08 PM Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Randallstown Baltimore . Social Security Alumber 216 – 36 – 36 – 36 68 Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) eb. 13,1942 1 M 2 XF Hours Min. Maryland Director 68 Feb. 212 40 2596 Decedent show 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Anne Arundel MD Arnold 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21012 USA 216 Baybourne Drive 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Examir 1 Never Married 2 X Married ö Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumarne) is marked o t. Page 1 and 2 should be fil tment of Health and Mental rant: If item 27 is marked ည Paul Jones Alice Gohr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 216 Baybourne Drive Arnold, MD 21012 Charles Reyeur / Husband Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State Metro Crematory, INC. Baltimore, MD 4 Donation 5 Other (Specify) 2010 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Errer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. End-Stage Cardiomyopathy Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last nding physician and use as the burial-transit Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 L Fetal dea 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atte page 2 should be detached for Month Day 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes 2 🗌 No 20 Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other Specific Treat hospice 1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be 2 Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MSRajupahre M.D 20057465 5/12/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N. S. RAPPAKSE, M.D. 2835 Smith AV., S-235 Baltimore, MD. 21209 31. Date filed (Month, Day, Year) State MAY 192010

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ichardson Physician/ Month eneva 2010 MAY 10:05 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death PRINCE GEORGE'S MILLENNIUM OF FORESTVILLE FORESTVILLE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Months Days Hours Min. Year 916 MAY 28 NORTHY CAROLINA Director 93 Yre 240-12-5304 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits Director 1 √ Yes 2 □ No PRINCE GEORGE'S SEAT PLEASANT MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 127 69TH STREET 20743 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black White etc ş 1 Never Married 2 Married BLACK 1 ☐ Yes 2 X No Specify: If Yos Give Il Hygiene. other than "natural", Specify Completed 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 7TH HOMEMAKER PRIVATE Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ UNKNOWN ALFRED CROMARTIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
127 69TH STREET SEAT PLEASANT, MARYLAND 20743 ANNIE HICKMAN/DGT 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Remo HARRISON CREEK CHURCH 5/27/2010 WHITE OAK, NO 4 Donation 5 Oth (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 1) ementia Onset and Death Physician/ vanced disease or condition resulting in death) Medical relmer is disease Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4x Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has After this certificate 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No. ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending M Natural injury work? 1 Yes 2 No To the russime. -. within 24 hours after death.

To the Funeral Director: Aft 5 Pendina Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse-Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu title of certifier 29d. Date signed (Month, Day, Year) 05-20 - 20 10 29c. License number 51520 2

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Division of Vital Records,

1328 SOUTHERN AVENUE SUITE 310 S.E. WASHINGTON, DC 20032

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signa

BAHRAM PISHDAD M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month May Physician/ 2010 19. 11:57 Bonnie Mae Renwick AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Aug. 28 1 🗆 M 2 🖾 F Days Hours Min South Carolina **Director** 577-48-8469 1935 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Hyattsville Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 6500 Riggs Road United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 10. 1 Never Married 2 3 Married 1 Yes 2 No If Yes, Give Completed by Baltimore, Maryland 21215-0036 Black 1 Yes 2 X No Specify. "natural", Specify: 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the May injury or other traumatic event the May injury or other trauma Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Government Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Fannie M. Rice Robert A. Glenn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20744 James R. Glenn/ Brother 1625 Taylor Avenue Fort Washington, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Harmony
Memorial Park 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State May 28, 4 ☐ Donation 5 ☐ Other (Specify) 2010 Landover, Maryland ture of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. Sig 20019 4001 Benning Rd. NE Washington, DC 23a. Part 1) Cyter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner acidos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last and nding physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No ō Day Month Pregnant at time of death signed by the a g 🗌 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was ar has autopsy performe death? Clostridian certificate 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA ည 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar

State

son who completed cause of death (Item 23a) (Type, Print)

Zana

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amedn #27 per MF G904 6/14/10 TT
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 05 05 63 M coner Medical 4a. Facility Name (if not institution give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Finere. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 8 Date of Birth 1 🗆 M 2 🗓 F Months Days 9/16/1924 218-16-0852 85 Director MD Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No Anne Arundel Jessup 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7965 Blobs Park Rd. 20764 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: White 3 → Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Walter Skopp Mary Olchowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Caplan Daughter 17709 Georgie Ave. Olney, MD 20832 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Cemetery 6/2/2010 Elkridge, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 17 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed ВХ Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Unknown signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Director: After this certificate I 1 Yes 2 No Yes 2 No 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1530 2 Accident Investigation 1 Yes 2 3 No 6 Could not be Suicide 28e. lace of njury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location Rereet and Number or Rural Route Number, 4 Homicide determined ime 24 hours Medical Certifying Physician. To the best of my knowledge, death occured at the time, date and place, and bue to the dause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature. 29c. License number 210 ath (Item 23a) (Type, Print) and address of person wh completed cause of g 31. Date filed Month, Day, 32, Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROPKA SMOUSE 905 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SUNRISE SILVERSPRING SILVER SPRING MONTGOMER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 **X** F 340-14-8688 Director Usual Residence of Decedent ıral", or items 23a or 28a-f show I Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MONTGOMERY SILVER SPRING MD 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral NEW HAMPSHIRE AVE 20904 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 'natural", 3 Widowed 4 □ Divorced Specify: WHITE Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) MEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည EMMORD WILLIAM ROPKA CATHERINE ELIZABETH SNELLING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra KARA CROMWELL, GRANDDAUGHTER 24673 STEWART ST, LOWALINDA, CA 92354 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite any injury or ott once. 1 Burial 2 Cremation 3 Removal from State 5/26/2010 PORT DEPOSIT, MD 4 ☐ Donation 5 ☐ Other (Specify) SBURY CEMETERY Signiture of Funeral Service Licentee 22. Name and Address of Facility LEEA. PATTERSON SON FUNCKAL HOME, P.A. PERRYVILLE, MD 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ATHEROSCLEROTIC CARDIOVASCULARDISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Day Year led by the a detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MCULATORY DYSPUNCTION, HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? DIABETES MELLITUS, FAILURE TO THRIVE 24a. Was an autopsy performe this certificate Yes 2 XNo 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗷 No ASSISTED LIVING 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Sp Phospital or Attending Phy 24 hours after death.
Funeral Director: After this leted filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident ☐ Accider☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) Myanson D53367 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHYAMSLINDAR LATAN 9801 GEORGIA AVE SUITE 117 SILVER SPRING, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

27 2019

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2010 Physician Mamie Lou Sanford May 13. 4:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Bradford Oaks Nursing Home Prince George's Clinton If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 □ M 2 □ F 577-74-1475 Director 85 May 31, 1924 Georgia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Madical Examiner must be notified at Director 1 TYPes 2 □ No Suitland Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3940 Bexley Place # 217 20746 Funeral United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🐴No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. within 72 hours after 1 ☐ Yes 2 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 9 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ۵ Specify: African 3 XWidowed 4 ☐ Divorced "natural", American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 6th s 1 and 2 should be filed with Hygier than 12 is marked other than 27 is marked other th Homemaker Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Sanford Lillie Pink Kendrick ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important: If item 27 any in]ury or other tr. 8419 Carrollton Parkway New Carrollton, Md. 20784 Carolyn A. Warren/ Daughter 20b. Place of Disposition (Name of cemetery crematory or other place)
Harmony 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Park 2010 Memorial Landover, Maryland 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Sigr 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARTIVIOSCLEST.E **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHRMic 1cinn & Oiseare Sequentially list conditions, Examine if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 🔊 No Day Year 5 Other (specify) P.0. the 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has t autopsy performed certificate 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death Director: 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide A 24 hours the Funeral Dire Hospital 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To th. within 2. 29b. Signature and title of pertifier 29c. License number 1 Course 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (ANNOMA Fort WASHINGTON

DHMH 17 Rev 1/2001

State Registrar

1174 LIVINSOM

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anne W. Simmons 2:57 P^M /18 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hillhaven Nursing Home Prince George's Adelphi 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** . Age (In yrs. last birthday) Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Washington, DC Director 577-50-7431 75 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5102 42nd Avenue 20781 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 Yes, Give 2 X No 1 ☐ Yes 2 X No Specify: 3 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Henry M. Fliedner Anna M. Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George I. Simmons / Husband 5102 42nd Avenue, Hyattsville, MD Baltimore, Important: If item 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Page 1 20c. Location - City or Town, State Tent of 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 5/20/2010 Alexandria, Virginia . Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Cardiomyopathy Medical Due to (or as a consequence of Examiner Congestive Heart Failure Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) lysician and ne burial-transit Exami Cause (Disease or iinjury Pulmonary Hypertension that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Hypertensive Heart Disease phy: attending p for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 🔀 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28d. Describe how injury occurred 1 X Natural 5 Pending death. n 24 hours after death. e Funeral Director: A eleted filled in by the fu Accident
Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Stru D46998 May 19, 2010

Box 68760

Ö

Records,

Division of Vital

State Registrar

Steven Tee,

Hamilton Street Suite #1, Hyattsville, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Begistra

MD,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MED CENTER Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** Months Days Hours Min Month, Day, You 1 🗆 M 2 MARYLAND Director 65 1944 217-40-6463 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No CALVERT OWINGS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20736 8206 FAIRFIELD DRIVE USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No BLACK "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 2+ CONTRACT SPECIALIST item 27 is marked other other traumatic event, i should be filed v Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ **EDNA** WATTY **ELIJAH JOHNSON** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 st tment of Health a tant; If item 27 is 8206 FAIRFIELD DRIVE OWINGS, MARYLAND ROBIN IMEL/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RESURRECTION CEMETERY 5/22/2010 CLINTON, MARYLAND Si pature of un r 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a Part Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed 24 hours after death. burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death been signed by the g 🗌 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Inknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy After this certificate | 1 ☐ Yes 2 🗓 No Yes 2 V the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 2 No Hospital 1 Yes Certificate: To Dipatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury (Aatural (Month, Day, Year) 5 Pending work? 1 ☐ Yes 2 ☐ No after death. Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined 24 hours Medical Pertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SNIDER Dav Vear Month **Physician** Alice BENTZ 1930 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner COUNTY GENERAL
T 6. Sex 7. A Columbia, HOWARD Howard 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Funeral Days 1 □ M 2 🛣 F Hours 88 219-14-9525 Dec. 4, 1921 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Evaminar must be notified at 1 ☐ Yes 2 🂢 No Director Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3004 North Ridge Road 21043 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: \$ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medical Lab Technician Medical permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygic Important: If Item 27 is marked other 1 any injury or other traumatic event, ID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Lawrence Bentz May Hagen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Craig A. Snider/Son 13439 Idlewild Drive, Bowie, Maryland 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 5/17/2010 Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home, 101-16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Conduvaruler Desens Examiner Alren sclenotic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine requires that the death certificate be executed and Due to (or as a consequence of): burial-Box 68760, physician Physician/Medical the as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mont ò Month Year 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed 1 ☐ Yes 2 ospital or Attending Physician: hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\text{\text{\text{Nursing Home}}}\) 8 \(\text{\text{Residence}}\) 8 \(\text{\text{Other}}\) 9 \(\text{\text{Oth 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After this 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 | Pending within 24 hours arter www.

To the Funeral Director: Aft 1 ☐Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type_Print)

Salsapath 201-108 Back Rens Mell Road Ballimon 32. Registrar's Signature

030641

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAY 2010 **EMRY** SULPH 7:42 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4624 DEEPWOOD COURT BOWIE PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. (Month, Day, Director 212-82-6204 195 JAMAĆIA ÁΝ Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland partnent of health and Mental Hygiene. The Maryland sortants if item 27 is marked outber than "natural", or items 23a or 28a-f show outsit if item 27 is marked outber than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No PRINCE GEORGE'S MD BOWIE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4624 DEEPWOOD COURT 20720 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give BLACK Specify. 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ABRAHAM SULPH MYRTLE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHELLE T. WILLIAMS/DGT. 10504 GLEN MANOR DRIVE BOWIE, MARYLAND 20720 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or otl Date 20c. Location - City or Town, State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) RESURRECTION CEMETERY 5/26/2010 CLINTON, MARYLAND J. B. JENKINS FONERAL ROME Signature of Run Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death arter Physician/ Coronary Medical resulting in death) Due to (or as a consequence of): **Examiner** Pertension Sequentially list conditions cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death
Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? Yes 2 X No 2**X** No To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: ပ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home St Residence 6 Other (Specify) hours after death.

Ineral Director: After this of filled in by the funeral dil Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending 1 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide in 24 hour.

o the Funeral Dr.
completed filler Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 5/18/10 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date file

32. Registrar's gnature

12150 ANNAPOLIS ROAD # 308 GLENN DALE, MARYLAND 20769

JAMALI M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Doris 2010 Smith 0350 M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Churchton Anne Arundel 5704 N Shore Parkway 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Days Hours Min 2/6/193 579-42-4682 Director 76 Usual Residence of Decedent or items 23a or 28a-f show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel 1 Yes 2 No Churchton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 5704 N Shore Parkway 20733 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ James H. Dabney Olive V. Hendrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Churchton, MD 20733 5704 N Shore Parkway Donald Smith Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 5/21/2010 Alexandria, VA Signature of Funeral Service Incensee 22. Name and Address of Facility 12 Ridgely Ave. Hardesty Funeral Home P.A. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ure Ph_sician/ rator disease or condition resulting in death) Medical consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death Other (specify) been signed by the should be detached 9 Unknown 9 Unknowi Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy 2 🗌 No 1 Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury 5 Pending work? Accident Investigation after death Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one

State

Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner TATE HOUSE HOSPICE OF THE CHESAPEAK LINTHICUM ANNE ARUNDEL Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Min. Hours 4-14-1936 MARYLAND Director 216-34-4871 74 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1X Yes 2 ☐ No DELAWARE SUSSEX OCEAN VIEW ō 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 23a Funeral 17 AMANDA'S COURT 19970 US items within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, o. 1 Never Married 2 Mamed Completed by 1 Yes If Yes, Give 2 💢 No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE "natural", 3 X Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER NONE Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ANTHONY F. LAUKAITIS URSULA WAITUKAITIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JAMES M. SULLIVAN/SON 2287 AUTUMN CT, ODENTON, MD. 21113 Saltimore. 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of DELAWARE VETERANS MEMORIAL CEMETERY 1 X Burial 2 Cremation 3 Removal from State 5/24/2010 4 Donation 5 Other (Specify) MILLSBORO, DELAWARE I neval s rvice Licensee 21. Signatura MELSON TUNEKAL SERVICES, LTD. 38040 MUDDY NECK ROAD, OCEAN VIEW, DE. 19970 e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee Onset and Dea or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown by. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed within 24 hours after death.

To the Funeral Director, After this certificate has been si completed filled in by the funeral director, page 2 should I 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No TATE မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b, Time of HOUSE 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Number Practice for To the basis of my investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the only one 29d. Date signed (Month, Day, Year) BA 12 31. Date filed (Month, Day, Year) State MAY 2 Registrar

DHMH 17 Rev 7/2009

			_ For	State of Ma								-		2
			State Registrar	-0		Cen	tificate	of De	eath		Reg. No).	1 1 1 7	Strage
	Physicia Medic	al		schecte	8					2. Date of De Month	eath 15	Year 2010	3. Time of Death	
	Examin	er	4a. Facility Name (if not institution, give Hebsew Home	e street and number) OF Great	erwa	shingt	4b. City, To		ocation of Deat	th		County of Dea		
	Funeral Director		0/4-0/-00/5	Sex 7. Age	(In yrs. las 99	st birthday) Yrs.	If Under 1 Months		If Under 24 Hrs Hours Min		rth 97, 129/]	9. Bi	rthplace (State or Foreig Bw ^{try} York	gn
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County DC			Town or Loc							10d. Inside City Limit	
	ith the Ma 23a or 28a st be noti	rał Dire	10e. Street and Number	+ N U			10f. Zip (_	tizen of What C	ountry?	
	ath w	Funeral	2939 Van Ness S	12. Was Decedent E	ver in U.S.	13. W	_	20008 ent of Hisr		pecify Yes or No		ted Sta		
9800	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒️ If Yes, Give Year or Dates.		If	Yes, specif	y Cuban,	Mexican, Puer	to Rican, etc.)		Black, Whi	e, etc.	
Baltimore, Maryland 21215-0036	hin 72 hou ne. than "nat e Medica	Completed	15. Decedent's t (Specify only highest g. Elementary/Seconday (0-12)				ent's Usual ind of work NOT use r	done du	on ring most of wo	rking	16b. k	Kind of Business	Industry	
	7 00 4	امها	17. Father's Name (First, Middle, Last)	2		Audi	itor			/5' h . h . f := t - t/-		d Govt		-
au	be filed ental Hy ked oth ic event	일	Isadore Mamat					,	Anna Hi	me (First, Middle	, ivialden	Surname)		
ar _Z	nd Me		19a. Informant's Name/Relationship (Type, Print)	Т	19b. Mailine	a Address (Street and		ural Route Numb	er. Citv o	r Town, State, Z	n Code)	
ž	id 2 sh ealth a n. 27 is ertra		Terri Karangele	n/Niece						nia Beac				
ore	e 1 an of He If iten or oth		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐	Removal from State	20b. Pla	ace of Dispos metery, crem	sition (Name	e of ner place)		Date	20c. L	ocation - City o	Town, State	
tim	t. Pag tment rtant: ijury o		4 ☐ Donation 5 ☐ Other (Spec	ify)	Na					23-2010		ls Chur	ch, VA	
Bal	permit. Page 1 and 2 should be filed Department of Health and Mental Hi Important: If item 27 is marked oil any injury or other traumatic even once.		21. Signature of a neral Service Liber	8						seph Gaw			INC DC 20016	
			23a. Part 1. Enter the disease, or com	plications has caused	the death.							nington	Approximate	
	hysician/	į,	shock, or heart failure. List only a Immediate Cause (Final disease or condition			to stir	nal	bled	d				Interval Between Onset and Death	
	Medical Examiner		resulting in death)	a. Gash Due to (or as a	conseque	nce of):		^ 1	- /					
		r e	Sequentially list conditions,	b. COPOT	wy	109-	eny	die	sease					
2	red nsit	Examiner	cause. Enter Underlying Cause (Disease or linjury	Due to (or as a	. conseque	ence ot):	•							
>	be executed sician and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a	conseque	ence of):								
0	ate be	dical		d			-						<u></u>	
687	ertifica Iding p	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnance	СУ						004 Data of da	di sana	
Box	he death c y the atten ched for u	Physician/Medi	in the past 12 months? 1 Yes 2 Aloo 9 Unknown	1 Live Birth 2 4 Pregnant at 9 Unknown			Ectopic pro Other (spe					23d. Date of de Month	Day Year	125
P.0	that the	by PI	Part II. Other significant conditions	contributing to death bu	it not result	lting in the un	nderlying ca	use giver	n in Part I.	23e. Did t	tobacco	use contribute to	the cause of death?	
ds,	equires sen sig ould b	ted								1 🗆	Yes 2	ODENio 3□F	Probably 4 Unknow	۸n
Division of Vital Records, P.O. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2 should be detached for use as the	Completed										prior to death?	utopsy findings available completion of cause of s 2 🗌 No	
ta	ician: sertific ector,	a B	25. Was case referred to medical examiner?	Hospital:				26. Plac Other:	e of Death (Che					
) {	Phys rthis ral dir	2	1 Yes 2 No	1 ☐ Inpatie 28a. Date of injur		R/Outpatient		c. Injury a		dome 5 Resi			cify)	
ion	ttending death. tor: After the fune	Certificate:	1 W Natural 5 ☐ Pending 2 ☐ Accident Investigatic 3 ☐ Suicide 6 ☐ Could not I	(Month, Day,	Year)	injury	М	work?	es 2 🗆 No					
Divis	urs after ral Direc		4 Homicide determined	building, etc.	(Specify)					City or To	vn, State)	ıral Route Number,	,
	To the Hospital within 24 hours a To the Funeral I completed filled	Medical	(Check 2 \(\subseteq \text{ Medical Exam} \)	vsician: To the best of national residual residu	amination a	and/or investi	gation, in my	y opinion,	death occurred	at the time, date	and place	e, and due to the	cause(s) and manner sta	ated.
_	vithi To th	_	20h Signature and title of certifier		-		00- 1	Linaman			00 1 5		. 5	
•	6		14600	N MI	>		D	69.	568		5/1	5/201	D	
	٦		30. Name and address of person who A. Chilakama? 31. Date filed (Month, Day, Year)	completed cause of de	ath (Item 2	3a) (Type, Pr	int)	aku	illed,	MD 20	85	2		
	Stat Registra	е	31. Date filed (Month, Day, Year) MAY 21 20		r's Signatur	re bar	Ked		•					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State o	of Marylan	_	artmen <i>tificate</i>			and M		giene Reg. No.	010	ę	7743
	Dharisis	-/	1. Decedent's Name (First, Middle	, Last)							2. Date of De Month	ath Day	Year	3. Tin	ne of Death
	Physicia Medic		Beverly Cal								May	14	2010	6:	45 a ^M
	Examin	er	4a. Facility Name (if not institution		nber)		4b. City, Town, or Location of Death					4c. C	ounty of Deat	h	
			Shady Grove					kvil		0411			ntgome		
	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. I	8 2Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	v. Year)	l Co	thplace (St untry Mi (ate or Foreign Chigan
	Director		578-30-8333 Usual Residence of Decedent			02.1.6.	ш				Aug 20	192	7		
7	show	ō	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Insid	de City Limits
1	Ra-f	rect	MD Montg	gomery	Bar	nesvil	1e							1XC	Yes 2 No
- 1	or 2	Ö	10e. Street and Number				10f. Zip	Code					on of What Co		
4	s 23e	Funeral Director	P.O Box	400			20	0838				Unit	ed Sta	ites	
1	item item	큔	11. Marital Status	Armed Fo	edent Ever in U.S	S. 13. V	Vas Deced	ent of His	spanic Ori	igin? (Spe	cify Yes or No- Rican, etc.)	14	. Race - Ame Black, White		n,
9	l", or	by	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes, Giv	2 🔀 No ve		I ☐ Yes							√hite	
3	atura cal E	Completed by		Year or D	ates.	16a, Deced	lant'e Heur	ıl Occups	ation						0
ς S	n "n Medi	ם	(Specify only highe	est grade completed		(Give I	kind of wor O NOT use	k done d		t of worki	ng	Cons	d of Business Sumer I	rodu	cts
77	iene jiene er the		Elementary/Seconday (0-12)	College (1	1-4 or 5+)				Secre	etary	,	Safe	ety Cor	nmiss	ion
ב ו	al Hyg	Be	17. Father's Name (First, Middle, I	Last)							e (First, Middle,	Maiden Su	mame)		
<u>a</u>	d be Menta arked artic e	유	Adelbert Sebas	tian Call	away				Blar	nche	Smith			_	
a l	and is m		19 Informant's Name/Relations			1	_				l Route Numbe				
2 ∘	ing z lealth im 27 her tr		Dana Worthing	ton, Daug					111e		l, Dick				
Baltimore, Maryland 21215-0036	ge I and 2 should be filed within 72 hours affer death with the warylain of Health and Mental Hygiene. If if the alth and Mental Hygiene is if them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition 1 Durial 2 Cremation	3 Removal from		Place of Dispo cemetery, cren	4'	46	e)		Date 21/2010		ation - City or		
	t. Pag tmen rtant: njury		4 Donation 5 Other (S	Specify)	l F			_					Lwood,	rial y	Tand
Ra	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trai		21. Signature of Funeral Service I	icensee M01	403						nple Tr		- MD	20052	
		10	23a. Part 1. Enter the disease, or	complications that	caused the deat						r respiratory a		e, mo	Approx	
_	husisian/		shock, or leart follule. List of Immediate dayse (Final)		ach line.			, ,	J.					Interva	Between and Death
	hysician/ Medical		disease or condition resulting in death)	a. Due to	Ischem (or as a conseq		itis								
	Examiner					,									
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	uence of):									
40	nd	wa	Cause (Disease or iinjury that initiated events	С											
00	cian a	a E	resulting in death) Last	Due to	(or as a conseq	uence ot):									
~ 7		edical		d											
20	ding	Ž	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregna	ancy						2,	3d. Date of de	liven/	
Box 687	atten for u	ciar	in the past 12 months? 1 Yes 2 No		Birth 2 Fet		Ectopic Other (sp		У			20	Month	Day	Year
. B	y the	Physician/Me	9 Unknown	g □ Unk	nown										
O.	ine law requires mat the rate has been signed by the page 2 should be detach	by P	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	underlying	cause giv	en in Part	: 1.	23e. Did 1	tobacco use	e contribute to	the cause	e of death?
S.	ulles an sig uld ba	ed									1 🗆	Yes 2	No 3□F	robably	4 🛣 Unknown
Ö	w red is bee	plet									24a. Was		24b. Were au		ings available n of cause of
မှို	ate ha	Completed									perf	ormed?	death?	s 2 😾 N	
a	ertifica ctor, p	Be C	25. Was case referred to medical examiner?							ath <i>(Ch</i> ec	k only one)				
>	nysic his ce il dire	ျ	1 Yes 2 X No		Inpatient 2			Othe	er: 4 🗌 N	lursing Ho	me 5 Res	idence 6	Other (Spec	cify)	
Division of Vital Records,	ing P	ate:	27. Manner of Death 1 🔀 Natural 5 🗌 Pendi	ng 28a. Date	e of injury oth, Day, Year)	28b. Time of injury	آ ا	8c. Injury work	?	- 1	28d. Describe	how injury	occurred		
o i	death tor: / the f	ij	2 Accident Investi	gation not be	6 h dayar - AA h		M		Yes 2	No	0011 11	70111		on (Do oto)	N
NIS	or An after of Direction by	Certificate:	4 Homicide detern		e of Injury - At he ling, etc. (Specif		eet, ractor	, опісе			28f. Location (City or To	Street and i wn, State)	Number or Ru	irai Route i	Vumber,
	in one nospital or Attenting Priystoan. within 24 hours after death. ♣ the Funeral Director: After this certific completed filled in by the funeral director,		29a. Certifier 1 Certifying	Physician: To the	best of my know	vledge, death	occured at	the time.	, date and	place, an	nd due to the ca	au s e(s) and	manner as st	ated.	
	n 24 h	Medical	(Check 2 Medical	Examiner: On the bag Nurse Practioner	isis of examination	on and/or inves	tigation, in	my opinio	on, death o	occurred a	t the time, date	and place, a	and due to the	cause(s) ar	nd manner stated.
	with la		29b. Signature and title of certifie			<u> </u>	т.		number				signed (Mont		ar)
	5		Beeinas	vonus.			I	0064	502			May 1	4, 201	0	
	_		30. Name and address of person						_						
			Brian Carpent					Dr.	Rock	vill	e,MD 20	850			
	Sta Registr		31. Date filed (Month, Day, Year) NAY 21	2010	Registrar's Signa	a pa	مري								

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 18, Physician 2010 0903 GLADYS BEATRICE SHEDRICK /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 🖺 F Director 579-48-3424 Washington , DC Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a, State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23s or 28s-1 ehow em hylury or other traumatic event, the Madical Examiner must be notified at once. 1 XYes 2 ☐ No Director Maryland Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13851 Belle Chasse 20707 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 □ Widowed 4 □ Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Payroll Clerk Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ethel Craig John L. Craig 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14151 Baweberry Circle Manassas, VA 20112 Woody Craig / Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation ☐ ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 5/21/2010 Laurel, Maryland 21. Signat of Funeral Service 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part 1 the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANTERIOSCIENOTIC CANDIOVASCULAR DISCOLO 4-PAR /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by failure Ventilator Dependent espinating 1 Yes 2 No 3 Probably 4 Unknown failure 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Dementia 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 No 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 Natural after death.

Director: All 1 Tes 2 No 2 Accident investigation 6 Could not be determined 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel [To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) May 18,2010 01852 rson who impleted cause of death (Item 23a) (Type, Print) veensbury Rd Hyattsville, Mb 20781 MD 4203 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ SHEETS Month EMILY 1319 MAE 2010 Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F Months Hours Min (Month, Day, Year) ntry) Maryland 213-16-1541 Yrs. Director 88 Aug. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Washington Smithsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22210 Jefferson Blvd 21783 U.S.A. filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) 12 Seamstress Draperies Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental | Important: If item 27 is marked of any Injury or other traumatic eve ٥ Franklin E. Doyle Geneva W. Leather 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harvey F. Sheets (Son) 5350 Salem Church Rd. Waynesboro, PA 17268 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) June 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland Smithsburg Cemetery 2010 Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home 12525 Bradbury Ave. Smithsburg, Maryland 21783 RE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COMM. ACQUIRED PNEUMONIA Physician/ BILATERAL disease or condition days Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence on). Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year signed by the aid be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MELLITUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL FIBRILLATION 24a Was an 124 hours after death.

• Funeral Director. After this certificate has termed filled in by the funeral director, page 2 s autopsy performed 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in rriy opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mb 20058181 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST. #306 HAGERSTOWN PEPRAH mb 21740 E. ANTIETAM KEDUAH 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

-

DX

State

Registrar

21702

Dr. Michael Tolino

Fraderick

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

HIN 0 7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 5/02/2010 7:39P M ELLA MAE THOMAS 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death TAKOMA PARK MONTGOMERY HOLY CROSS HOSPITAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 ☐ M 2 ☐ F Yrs 173-24-1854 89 9/10/1920 COLUMBIA, SC Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 14 Yes 2 □ No MD MONTGOMERY TAKOMA PARK 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 614 SLIGO AVE #406 UNITED STATES 20910 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐Yes 2 € No Black White etc 1 ☐Yes 2 € If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: BLACK 3₺ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TEACHER 12 DC PUBLIC SCHOOLS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SALLIE CHICK CLEVE TALLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TANKA NEWMAN / GRANDAUGHTER 1310 DENNIS AVE SILVER SPRING, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT LINCOLN 5/17/2010 BRENTWOOD, MARYLAND of Funeral Service 22. Name and Address of Facility JOHN T. RHINES FUNERAL HOME, LLC 3005 12TH ST. NE WASHINGTON, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CORONARY ARTERY DISEASE disease or condition resulting in death) Due to (or as a consequence of) DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

the attending physician

requires that the death certificate be executed

Physician:

or Attending death.

Hospital

2

this After

within 24 hours after death To the Funeral Director: filled in by

completely

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

Funeral

Director

7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Eventher must be notified a

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

should be filed within and Mental Hygiene.

Pages 1 and 2 s ment of Health ar

Health and Mental Hygidem 27 Is marked other

permit. Pages 1 an Department of Heal Important: If item 2 any injury or other

other 1

Examiner use as the burial-trai detached cate has been signed by page 2 should be detach funeral director

Physician/Medical þ Be Completed Certification: To Medical

30. Name and address of person wh

EDDIE EERNANDEZ,

	d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		pic pregnancy er (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underly	ing cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
DEMENTIA			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
			24a. Was an autopsy performed? 1 □ Yes 2 ☑ No 1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of Deat	h (Check only one)
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ← ER/Outpatient 3 [DOA Other: 4 Nursing Ho	me 5 Residence 6 Other (Specify)
27. Manner of Death 1 → Natural 5 □ Pending 2 □ Accident investigation		28c. Injury at Work?	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier 1 → Certifying Ph (Check only one) 2 → Medical Exam	nysician: To the best of my knowledge, death occuniner: On the basis of examination and/or investig and mannar stated.	urred at the time, date and place, ation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

1500 FOREST GLEN ROAD, SILVER SPRING, MD 20910

D64008

5-02-2010

Registrar

State

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signal

P.0. Division of Vital Records,

after death Director: within 24 hours a

WIL 10-4118

State Registrar

31. Date filed (Month, Day,

determined

e of certifie

30. Name and address of person who come

4 Homicide

29a. Certifier (Check only one) 29b. Signature a

leted cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

165thiuster, 410 21157

29d. Date signed (Month, Day, Year)

			For State	State of Ma	-	epartment of Certificate of		nd Mental		71111	17749
		-	Registrar 1. Decedent's Name (First, Middle, La	st)			Dealli	2. Date	Reg. N	lo	3. Time of Death
-	Physic		Eli Henry Time	,				Mont		201	
	/Medi Examii		4a. Facility Name (If not institution, gir			4b. City, Town,	or Location of			c. County of Dea	
-			Berlin Nursing	& Rehab	Ctr	Berlin	1			Worcest	cer
	Funeral			. No	e (In yrs. last birth	Months Day		Hrs. 8. Date Min. (Mon	of Birth th, Day, Yea	9. Bi	rthplace (State or Foreign ountry)
	Director		217-42-5552 Usual Residence of Decedent	1MM 2LIF 66	Yı	S.		3-2	28-19	44 MD	
	/land		10a. State 10b. County		10c. City, Town of	or Location					10d. Inside City Limits
	Mar a-f st	ctor	MD Worcest	er	Berlin						1 □ Yes 2 🕍 No
	or 28	Dire	10e. Street and Number			10f. Zip Code)		10g. 0	Citizen of What C	ountry?
	s 23a	ra	10238 Camelia		- · · · · - · · · · · · · · · · · · · ·	21811			US.	T	
i 21215-0036	s.1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Eventhar must be nettined at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 Tyes 2 Th If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 No.		n? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Am Black, Whi	te, etc.
0-9	2 hou	ted	15. Decedent's E	ducation		ecedent's Usual Occ			16b.	Kind of Business	s/Industry
21	ithin 7 ne. Man "r	Completed by	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5		Give kind of work don ife. DO NOT use reti	red)	or working		rpentry	·
- T	D 0 0	ပ္ပ	1 1 17. Father's Name (First, Middle, Las		Mai	ntenance		cer s Name <i>(First, N</i>		dustry	
anc a	d be fi	Be	Fletcher Timmo					ie Sper		en Surname)	
sr\z	should Me mark	은	19a. Informant's Name/Relationship		19b. I	Mailing Address (Stre				y or Town, State,	Zip Code)
Ma	alth a 27 is		Tammy Timmons	Daughter	[6 Pattey					
mm ore,	es 1 a of He of He fittem		20a. Method of Disposition		20b. Place of D	Disposition (Name of crematory or other p	_ i	Date	20c.	Location - City o	r Town, State
Ti	Page ment ant: It		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		-Çalvar	y UMC Ce				rlin, N	
Timmons, El Baltimore, Maryland	permit. Pages 1 Department of h Important: If ite any Injury or ot once.		21. Signature of Eunoral Service Lice	nsee		22. Name and Add Bennie S	tress of Facility				
	0.0 = 40 O		23a. Part 1. Enter the dise 18., or con	Tell	4	Funeral	Home			MD 218	F-3-2
100	- Sergianus in		shock, or heart failure. List of	one cause on each li	e.				-		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Kight	a consequence	aden	ocurc	inomo			
	Examiner				a consequence y						
	P #	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):					
	ecute and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c							
60,	icate be executed physician and the burial-transit	<u></u>	resulting in death) Last	Due to (or as	a consequence of): -					
68760,		dical		d							
Box	Attending Physician: The law requires that the death certific reath. ector: After this certificate has been signed by the attending the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)				23d. Date of d Month	elivery Day Year
P.0	that the	Phy	Part II. Other significant conditions	contributing to death b	ut not resulting in t	he underlying cause	given in Part I.	23e	. Did tobacc	o use contribute	to the cause of death?
of Vital Records,	quires en sign	ed by							1 🗆 Yes	2 □ No 3 1	Probably 4 🗌 Unknown
ecc	law re as be 2 sho	Completed						24a	. Was an autopsy	24b. Were a	autopsy findings available completion of cause of
<u>=</u>	The cate h	l G						1 🗆	performed?	? death?	s 2 No
Vita	lcian: certific ector,	Be	25. Was case referred to medical examiner?	Hespital				of Death (Check	only one)		
of	Phys rthis ral din	P:	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie	ent 2 ER/Outp	atient 3 DOA				6 ☐ Other (Sp	pecify)
on	ding h. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	y, Year) Inj		njuryat /ork? □Yes 2 □N		scribe now in	jury occurred	
Division	Atter r dea ector by the	ifica	3 Suicide 6 Could not	28e. Place of Inju	ury - At home, farr	n, street, factory, offic		28f. Loca	ation (Street	and Number or I	Rural Route Number,
Ö	ital or irs afte al Dire	Certification: To	4 ☐ Homicide determined	building, et	с. (Ѕресіту)			City	or Town, St	ate)	
	To the Hospital or Attending Physician: The law requires that the de within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a completely filled in by the funeral director, page 2 should be detached	Medical	(Check only 2 Medical Exa	hysician: To the best miner: On the basis of LG., and manner sta	f examination and						
	vithi Voithi	Ž	29b. Signature and title of certifier	71	2.0	29c. Lice	nse number	21		Date signed (Mo	
			Illune da	vag 4	aup		1351	21	Ma	ay 20,	2010
	OND		30. Name and address of person who				_	.12		1011	
		ate	Pennie Savage, 31. Date filed (Month, Day, Year)		115 Hea ar's Signature	lthway D	r, ser	iin, M	ט 2	1811	
	Regist		MAY 24		m B.	park					

Anthony Lamont Thompson

Please 1

Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.	t my leg	pre 10
State of Maryland / Department of Health and Mental Hygiene	177	DI
O45515D41		

Control Permitted Cont			1- For State Registrar		Cer	tificate of	Death			Reg. N	lo.				
May 23, 2016 May	Physici	an/											3. Time of Death		
The Facility Name of the reduction of the control coates and Anne Anne Anne Mode Mode Call Center 1 Shows the search further of the coates of	Medical Exami	iner	Anthony Thom	ıpson								r	1311 hrs		
Anne Anndel Medical Center Anne Anndel Medical Center 13 - 02 - 995 8	4		4a. Facility Name (if not institution	on, give street and n	umber)	1.	4b. City, Town, o	or Location of D				f Death			
Stock Set by Number Color 2 April by 1 2 2 2 3 2 2 3 2 2 3 2 3 2 3 3					,	ŀ									
213-02-9958 K	Eumaral		5. Social Security Number	6 Sev	7 Ane (In yrs Is	ast hirthday)			4Hrs Is Data	of Righ (M	MUDDAAAA	O Die	halaca (State or		
The street is control of the property of the street of the street is control of the street of the street is control of the street is control of the street of the street is control of the street is					7. Age (iii yis. ie										
The state of the	Director		213-02-9958	1X M 2 F		Z / Yrs		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	""" Joet	21	1902	ego	яну)у тапо		
Maryland Anne Arundel Annapolis 10 Victor Parkway 11 Nareal statuse 11 Nareal statuse 12 Nareal status 12 Nareal status 13 Nareal status 14 Nareal status 15 Nareal status 15 Nareal status 16 Nareal status 17 Nareal status 17 Nareal status 18 Nareal status 18 Nareal status 18 Nareal status 18 Nareal status 19 Nareal st															
The control of the co	any												•		
The control of the co	nd show	Ē	Maryland Anne	Arunde:	1 A	nnapol	lis						1 Yes 2 No		
The control of the co	uryla 8a-f.: af on	çç	10e. Street and Number				10f. Zip Code	-		10a. C	itizen of Wha	at Cour	trv?		
Second Continued	e Mi	ire	101 Victor F	arkway						13		.,	,		
Second Continued	ith th														
Second Continued	th w	Jer		A of C									can Indian, Black,		
Cheryl Lynn Brown (Mother) 40 Belle Ct. Annapolis, Md. 21401 Zoa Memora of Disposion 1/Sevinte 2/Date 2 Commission 2/Date 2 Commi	or it	Fu		1 Yes						•					
Cheryl Lynn Brown (Mother) 40 Belle Ct. Annapolis, Md. 21401 Zoa Memora of Disposion 1/Sevinte 2/Date 2 Commission 2/Date 2 Commi	afte iner",			or Dates:		1	Yes 2 N	lo specify:			Specify:	Bl	ack		
Cheryl Lynn Brown (Mother) 40 Belle Ct. Annapolis, Md. 21401 Zoa Memora of Disposion 1/Sevinte 2/Date 2 Commission 2/Date 2 Commi	nours xam	þe			de completed)					16b	. Kind of Bus	iness/Ir	ndustry		
Cheryl Lynn Brown (Mother) 40 Belle Ct. Annapolis, Md. 21401 Zoa Memora of Disposion 1/Sevinte 2/Date 2 Commission 2/Date 2 Commi	72 h	lete		College (1-4 or 5+)	-		ie. DO NOT use	retired)						
Cheryl Lynn Brown (Mother) 40 Belle Ct. Annapolis, Md. 21401 Zoa Memora of Disposion 1/Sevinte 2/Date 2 Commission 2/Date 2 Commi	030 ithin r tha	ш	12th	0		Ca	ashier			N	1cDon	ald	S		
Cheryl Lynn Brown (Mother) 40 Belle Ct. Annapolis, Md. 21401 Zoa Memora of Disposion 1/Sevinte 2/Date 2 Commission 2/Date 2 Commi	ed w lygie of the ly	ပ္ပ	17. Father's Name (First, Middle	, Last)				18.Mother's N	lame (First, Mic	ldle, Maide	en Surname)				
Cheryl Lynn Brown (Mother) 40 Belle Ct. Annapolis, Md. 21401 Zoa Memora of Disposion 1/Sevinte 2/Date 2 Commission 2/Date 2 Commi	215 e file tal H ked nt, ti		Tyrone Thomp	son				Cher	yl Lyn	n Br	cown				
Cheryl Lynn Brown (Mother) 40 Belle Ct. Annapolis, Md. 21401 Zoa Memora of Disposion 1/Sevinte 2/Date 2 Commission 2/Date 2 Commi	21, Men Men mar		19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailing	Address (Stre	eet and Number	or Rural Route	Number.	City or Town	State	Zip Code)		
Comparison of the Part Comparison of the	O g B is in	-	Chervl Lvnn	Brown (Me	other)						-		· ·		
Comparison of the Part Comparison of the	and 2														
Comparison of the Part Comparison of the	of H			n 3 Removal fr	om State C	rematory or oth	ner place) *			- 1		•			
23. Part I. Enfer the disasse/ or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart detheren complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart detheren complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart detheren constant and detheren constan	Page Page ant:				U	.M. C	nurch	6	-1 - 10	I F	Annapo	011	s, Md.		
23. Part I. Enfer the disasse/ or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart detheren complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart detheren complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart detheren constant and detheren constan	mit.					2 WN	ame and Report	G Fability S	ons Mo	rtua	ary,	' . A			
Physician (Mosting Standard Course (Freal disease) and the feath (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (List only, one cause or each line). Physician (Mosting Standard Course (Freal disease) and the feath (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feature (Do not enter the mode of dying and such arrest (Do not enter the mode of dying and such arrest (Do not enter the feature of the spiratory arrest (D	E.F.P.E.		Lang D. Reese MOO483 821 West St. Annapolis, Md. 2140												
The control of the course of each interest in the control of the course of each interest in the control of the course of each interest in the control of the course of each interest in the control of the course of each interest in the condition resulting in death) The control of the course of each interest in the condition resulting in death) Due to (or as a consequence of):	Physician		23a. Part I. Enter the disease/or	complications that of	aused the death.	Do not enter th	ne mode of dying	g, such as cardi	ac or respirator	y arrest, s	hock, or hear	rt	Approximate Interval		
System of the part of the past				***											
Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Pieses or Injury Material Cause.) Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Pieses or Injury Material Cause.) Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Pieses or Injury Material Cause.) Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Pieses or Injury Material) Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Pieses or Injury Material) Sequentially list conditions, flary, leading to immediate cause. Enter Underlying Cause (Pieses or Injury Material) Sequentially list conditions.	Examiner					١.						-	Deali		
The color of the			J	Due to (or as a	consequence of).									
AMENDED 27, 28a-f, per ME g905 7/30/10 TT Superior of the properties of the prope		<u>-</u>		Due to (or as a	consequence of	J.						-			
AMENDED 27, 28a-f, per ME g905 7/30/10 TT Superior of the properties of the prope		إ	cause. Enter Underlying Cause	C	oonsoquence or	7.						3			
AMENDED 27, 28a-f, per ME g905 7/30/10 TT Superior of the properties of the prope		ащ		Due to (or as a	consequence of):						_			
The past 12 months? Part II. Other significant conditions Part II. Other signifi	uted	ω̈́		d.											
The past 12 months? Part II. Other significant conditions Part II. Other signifi	exec an ar al - t	isa	XUNPENDED	AMENDED_				100110							
The past 12 months? Part II. Other significant conditions Part II. Other signifi	se be	필		23a,2	7,28a-f	per ME	g905 /	/30/10	TT						
The of the standard of the sta		\geq	23b. Was decedent pregnant in th	230. II yes,	outcome or pregn	laricy				2		,	av Voor		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1	C 68	Si.	past 12 months?			ath 🗀			griaricy		MOUL	D	ay real		
3 Suicide 6 Could not be determined (Specify) Center Prison Cell Annapolis, MD 28e. Place of Injury - At home farm-streat factory office building attention or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O. C.M.E. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier O. C.M.E. May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	30) death e att	ysi	1 Yes 2 No 9 Uni		own	3 <u> </u>	iei (Specify)			- 17					
3 Suicide 6 Could not be determined (Specify) Center Prison Cell Annapolis, MD 28e. Place of Injury - At home farm-streat factory office building attention or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O. C.M.E. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier O. C.M.E. May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	O. E.	됩	Part II. Other significant condit	ions contributing to	o death but not re	sulting in the u	nderlying cause	given in Part I.	23e. l	Did tobacc	o use contrib	ute to t	ne cause of death?		
3 Suicide 6 Could not be determined (Specify) Center Prison Cell Annapolis, MD 28e. Place of Injury - At home farm-streat factory office building attention or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O. C.M.E. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier O. C.M.E. May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	P. C	Ď				-			1	Yes 2	No 3	Proba	abiv 4 V Unknown		
3 Suicide 6 Could not be determined (Specify) Center Prison Cell Annapolis, MD 28e. Place of Injury - At home farm-streat factory office building attention or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O. C.M.E. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier O. C.M.E. May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	quire an signid b	ted		· · · · · · · · · · · · · · · · · · ·											
3 Suicide 6 Could not be determined (Specify) Center Prison Cell Annapolis, MD 28e. Place of Injury - At home farm-streat factory office building attention or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O. C.M.E. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier O. C.M.E. May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	w re	흺													
3 Suicide 6 Could not be determined (Specify) Center Prison Cell Annapolis, MD 28e. Place of Injury - At home farm-streat factory office building attention or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O. C.M.E. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier O. C.M.E. May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	he la	티											2 No		
3 Suicide 6 Could not be determined (Specify) Center Prison Cell Annapolis, MD 28e. Place of Injury - At home farm-streat factory office building attention or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O. C.M.E. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier O. C.M.E. May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	T: T		25. Was case referred to medica				26 Plac	e of Death (Che		C3 Z	140	V 100	2 110		
3 Suicide 6 Could not be determined (Specify) Center Prison Cell Annapolis, MD 28e. Place of Injury - At home farm-streat factory office building attention or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O. C.M.E. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier O. C.M.E. May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	irect		examiner?	Hospital:	Innationt 2	ED/Outpatient		Othor -		Posi	dones e	Othor			
3 Suicide 6 Could not be determined (Specify) Center Prison Cell Annapolis, MD 28e. Place of Injury - At home farm-streat factory office building attention or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O. C.M.E. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier O. C.M.E. May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Phy Phy cral d	-						1 110							
3 Suicide 6 Could not be determined (Specify) Center Prison Cell Annapolis, MD 28e. Place of Injury - At home farm-streat factory office building attention or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number O. C.M.E. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 131 Jennifer Road Annapolis, MD 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier O. C.M.E. May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	ding Aft	ᇹ	1 Natural	(Month	, Day,Year)	200. Time of it									
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		aţi	Pend	stigation Fd 8/			/ am —			JC IIA	inged i	CII			
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Vis or A or A Direction by	ij	3 X Suicide 6 Coul	d not be 28e, Plac	e of Injury - At hou	me farm stree	tofactory office	etentio	n 28f. Locat	on (Street	and Number	or Run	Route Number City		
29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) May 24, 2010 Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	pital purs a	<u>F</u>	4 Homicide deter	mined (Specify)	Center	Prison	Cel1		Annana			.1111.7	Tel Road		
O.C.M.E. OCME May 24, 2010 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Hos 24 hc Fun tely f		29a. Certifier 1 Certifying Pl	nysician: To the bes	st of my knowledg	e, death occurr	ed at the time, o	date and place,	-	-		s state	d.		
O.C.M.E. OCME May 24, 2010 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	thin the	9		miner: On the basis	of examination an										
Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	F F	ş	29b. Signature and title of certifie		ialeu.		29c. Licen	se number		29d	. Date signed	(Mon	h, Day, Year)		
30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201			11.	. 1.		\			OCME				2		
Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		Į	1 hudere	U. King	JRus	u.D.				IVIC	~, ~¬, ~∪)				
				,			444.5								
State 31. Date filed (Month, Can Year) 2010 32. R gistrar's Signature			- ·				111 Penn S	treet, Baltim	ore, MD 21	201					
		ate	31. Date filed (Month, Day Year).	2010 32. B	gistrar's Signatur	e/ /.	.v.I								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death 14 Day 2010 Year Physician/ Month MAY THOMAS JR. MERRILL 11:40 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5603 CARTERS LANE PRINCE GEORGE'S RIVERDALE 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours Min. NOV 5 1938 WASHINGTON, DC 71 Yrs. Director 215-36-5614 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No PRINCE GEORGE'S MD RIVERDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5603 CARTERS LANE 20737 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 2 No ARMY Completed by Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: and 2 should be filed within 72 hours afte Health and Mental Hygiene. tem 27 is marked other than "natural", If Yes, Give 3 ☐ Widowed 4 🏋 Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12TH BUS DRIVER PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MERRILL THOMAS HAZEL SIMMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORENZO THOMAS/SON 5603 CARTERS LANE RIVERDALE, MARYLAND 20737 Department of Healt Important: If item 2 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) cemetery, crematory or other place) injury or 3 Bernoval from State MD VETERANS CEMETERY 6/3/2010 CHELTENHAM, MARYLAND 22. Name and Address of Facility $\, {\sf J.} \, \, \, {\sf B.} \, \, \, {\sf JENKINS} \, \, \, {\sf FUNERAL} \, \, \, {\sf HOME}$ 21. Signature of Funeral Service Licensee <u>7474 LANDOVER ROAD LANDOVER MARYLAND</u> 23a. Part 1. Enter the state of complications that states the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ APPENDIX CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2**X** No 1 Tes Yes To the Funeral Director; After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred or Attending Fafter death. 1 XNatural 5 Pending iniury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined City or Town, State) Hospital 24 hours a Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one) 29b. Signature and title 29d. Date signed (Month, Dav. Year)

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARL KASAMON M.D.

Date filed (Month, Day, Year)

MAY 2 5 2010

D005877

5450 KNOLL NORTH DRIVE SUITE 140 COLUMBIA, MARYLAND 21045

2010

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Ple	ase Type or Pri						_		_	ible.	
	-	For State Registrar	State of M	aryland /		artment of <i>tificate of</i>		and N	∕lental Hy	_	20	10	17752
Dharisis	- /	Decedent's Name (First, Midd Douglas		· · · · · ·		imoute or	Dogin		2. Date of De			Year	3. Time of Death
Physicia Medic	al	4a. Facility Name (if not institution		, <u>r</u>		41.00 - 75		(D !!	Month May	40'			
Examin	er	Manor Care of	,			4b. City, Town,	or Location otoma				County of County		7
Funeral Director		5. Social Security Number 149–14–4854	6. Sex 1 X M 2 \(\subseteq \) F	je (In yrs. last b	irthday) 6 Yrs.	If Under 1 Yea Months Days		Min.	8. Date of Bir (Month, Da Jun. 8,	rth ay, Year) 192	23	9. Birthp Count Virg	elace (State or Foreign try) pnia
and show	or	Usual Residence of Decedent 10a. State 10b. Count		10c. City, To	wn or Loc	ation						1	0d. Inside City Limits
Maryli 28a-f	irect		N/A				ashing	ton					1 X Yes 2 No
with the s 23a or ust be r	Funeral Director	10e. Street and Number 1519 Underwo	ood Street, NI	N		10f. Zip Code 20	012				itizen of W ited		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ğ	11. Marital Status 1 ☐ Never Married 2 ☐ M. 3 ☐ Widowed 4-™ Divorce	If You Cive 1	Nº 3-	1	Vas Decedent of Yes, specify Cul ☐ Yes 2 ☑ N			ecify Yes or No- Rican, etc.)	14. Race - American Indian Black, White, etc. African Specify: A m ericar			can
thin 72 hou sne. than "natu he Me dical	Completed		ent's Education hest grade completed) College (1-4 or t		(Give k	ent's Usual Occi ind of work done ONOT use retired Ination	durina mos	st of work	ing L		Kind of Bu		
be filed wi lental Hygie rked other ic event, ti	To Be (17. Father's Name (First, Middle John Living	Last)				18. Moth	ner's Nam	e (First, Middle,)	
id 2 should saith and M n 27 is mai er traumat		19a. Informant's Name/Relation Marian T. Tyra	ship (Type, Print) ance / sister	. 19	9b_Mailin 1519	g Address (Stree Underwo	t and Numb	er or Bura • , NW	al Route Numbe Washi	er, City o ng t c	n Town St	^{tate} 200	ode)
Page 1 arment of He tant: If iten		20a. Method of Disposition 1 🛣 Burial 2 🗌 Crematio 4 🗍 Donation 5 🗍 Other	n 3 🗌 Removal from State (Specify)	cemei	tery, crem	sition (Name of latory or other pl oln Cem			Date 4/2010		ocation -		wn, State aryland
permit Depart Impor any in		21. Signature of Furgeral Service	Licensee		22. 7	Name and Add	ess of Facili	y Mc	Guire F	uner	al Se	ervice	e, Inc. OC 20012
		23a. Part 1. Enter the disease, shock, or heart failure. List	or complications that caused only one cause on each line	d the death. Do							<u> </u>		Approximate Interval Between
Physician/) Medical		Immediate Cause (Final disease or condition resulting in death)	Dementia,	Vascu:									Onset and Death
Examiner		Sequentially list conditions,	Alzheimer										
sit s	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as	a consequence	e of):								
e E E	cal Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):											-
tificate ng phys as the	Medi	IF FEMALE:	d										
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal dea	ath 3 🗌 n 5 🗆	Ectopic pregna Other (specify)	ncy				23d. Date Mor	e of delive	ory Day Year
s that the gned by be deta	ا ۾	Part II. Other significant condit Prostate Ca:		out not resulting	g in the ur	nderlying cause	given in Part	1.					e cause of death?
require been s should	Completed								1 L				ably 4 Unknown
he law te has page 2 s	dwo				_				auto	psy ormed?	P		npletion of cause of
ician: T	Be	25. Was case referred to medica examiner?	Hospital:				Place of Dea	ath (Check		2 🗀 19	10] .		
g Phys er this c eral dir	e: To	1 ☐ Yes 2 ♣ No 27. Manner of Death	1 ☐ Inpati 28a. Date of inju	ent 2 ER/0	. Time of	28c. Inju	ıry at		me 5 Resi	_			
tending leath. tor: Aft the fun	Certificate:	1XXNatural 5 ☐ Pend 2 ☐ Accident Inves 3 ☐ Suicide 6 ☐ Coul-	tigation		injury		Yes 2	No					-
ital or At urs after o ral Direct lled in by		4 Homicide deter	mined 28e. Place of Inju- building, etc	c. (Specify)					28f. Location (\$ City or Tov	vn, State	e)		·
e Hosp 124 hor e Fune eleted fi	Medical	(Check 2 <u>U</u> Medical	ng Physician: To the best of Examiner: On the basis of e ng Nurse Practioner: To the	xamination and	or investi	gation, in my opir	nion, death o	ccurred at	the time, date a	and place	e, and due	to the cau	se(s) and manner stated
To the withing the comp		29b. Signature and title of certifi		100	~ •		se number	o de la piac		29d. Da	ate signed	(Month, E	-
		30. Name and address of person Gary B. Wilk.	n who completed cause of d s, MD 77	58 Wis	cons	in Avenu	ie, Su	ite#	211, Be	thes	sda,M	D 208	314
State Registra	_	31. Date filed (Month, Day, Year)	010 32Registr	ar's Signature	back	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 0410 M Ray E. Taylor Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death WMHS-Regional Medical Allegany umberlano Social Security Number 6. Sex 1**X** M 2 □ F If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Hours Shenadoah, 216-18-9612 Director 85 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Hampshire Augusta 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral F HC 71 Box 229 26704 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business Industry al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental P Important: If Item 27 is marked of any injury or other traumatic evea once. and Mental F ည David E. Taylor Bernice E. Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 71 Box 231 Cheryl Davis Augusta, WV 26704 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 5-30-2010 Morgantown, WV WVU Memorial Vault PO Box 9131 Signature of Funeral Service Licensee 22. Name and Address of Facility Human Gift Registry Morgantown, WV 26506 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ piration AS disease or condition dews Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. the attending physiclan and hed for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 2 No 9 Unknown 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate 1 Yes 2 No Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes Hospita 2 Z No Other Certificate: To 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pendina 1 Yes 2 No after death Director: / Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

Registrar

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

an

D21244

Broadway Frostburg, Maryland 21532

10-03720 Keith A. Vereen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

10	7	1	5	Part of
----	---	---	---	---------

			1- For State Critical	e of Death	Reg. No.	1104
Р	hysicia	_	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
edical			Keith A. Vereen		Month Day Year May 15, 2010	0017 hrs
			4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Deatl	
			5702 Martin Luther King Highway	Seat Pleasant	Prince George	e's
	ıneral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo		. 8. Date of Birth (MM/DD/YYYY) 9. Bir	thplace (State or Foreign ountry)
Dir	rector		$219-96-6257 \mid X _{M} \mid 2 _{F} \mid 43$	Yrs. Months Days Hours Min.	03/13/1967 D	
		. I	Usual Residence of Decedent			
	v any		10a. State 10b. County 10c. City, Town or			10d. Inside City Limits
and	Sho once.	5	MD Prince George's Hyatts	ville		1 X Yes 2 No
Mary	28a-	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	ntry?
n the	3a or		5031 36th Place	20782	U.S.A.	
h with	ems 2	Funeral	11. Mantal Status 1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		ican Indian, Black,
r deat	or it	튑	1 Yes 2 A No		RI	ack
safte	ral",	۾	or Dates:	1 Yes 2 No specify:	Зреспу.	
hour	"natu Exar	ted		ing most of working life. DO NOT use reti		industry
36 iin 72	than	e d		Construction Wor	ker Private	•
-00 d with	/gienc	Completed	12th 17. Father's Name (First, Middle, Last)	18.Mother's Name	(First, Middle, Maiden Sumame)	
21215-0036 ould be filed within 7	ked o	Be	William Vereen	Rakeco	D. Anderson	
21 ould b	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	힏	19a. Informant's Name/Relationship (Type, Print)	Mailing Address (Street and Number or F 31 36th Place, H	Rural Route Number, City or Town, State	e, Zip Code) 20782
MD MD sho	th an 27 i	Į				
ē , 18	f Hea If iten er tra		Crematory	Disposition (Name of cemetery, or other place)	Date 20c. Location - City or	
Baltimore,	ant:		4 Donation 5 Other Specify:		7/2010 Suitland	
alti mit.	partn port		21. Signature of Funeral Service Licensee	22. Name and Address of Facility DI 2019 MLK Jr Ave	McLaughlin Fur	eral Home
m &	ద్.క		huy/fin			
	sician edical		23a. Pan 1. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.	nter the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and
	miner		Immediate Cause (Final disease a. Multiple Gunshot Wounds		-	Death
			or condition resulting in death) Due to (or as a consequence of):			
		ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
		miner	cause. Enter Underlying Cause (Disease or injury that initiated c			
g	and - transit	Exa	events resulting in death) Last Due to (or as a consequence of):			
executed	an and al - tra		d. UNPENDED AMENDED		<u> </u>	
68760, certificate be e	ned by the attending physician detached for use as the burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	
	ing pl		23b. Was decedent pregnant in the past 12 months?	Fetal death 3 Ectopic pregna		Day Year
Box 687 e death certific	attend or use	Physician/	4 Pregnant at time of death 5	Other (Specify)		
. D	y the	h	Part II. Other significant conditions contributing to death but not resulting in	the underlying course given in Part I	23e. Did tobacco use contribute to	the cause of death?
Records, P.O. I	as been signed by the should be detache	by	Tart ii. Other algumeant containons	The underlying cause given in Fart i.	1 Yes 2 ✔ No 3 Pro	
duire	en sig uld be	ted			24a. Was an 24b. Were a	utopsy findings available
SOTC aw re	as be	ıple				completion of cause of
		Completed			1 ✓ Yes 2 No 1 ✓ Y	es 2 No
Gian:	his certif director,	Be (25. Was case referred to medical examiner? Hospital: 1 Innatient 2 FR/Quital	26.Place of Death (Check atient 3 DOA Other Nursin		
f < i	er this	To	1 Yes 2 No	atient 3 DOA Other Nursing of Injury 28c. Injury at Work?	g Home 5 Residence 6 ✓ Othe 28d. Describe how injury occurred	er: Scene
n o	h. After t funeral	on:	27. Manner of Death 28a. Date of Injury 28b. Tin 1 Natural 5 Pending May 15, 2010		Subject shot	
Sio	ector: by the	cati	2 Accident Investigation 28e Place of Injury - At home farm		28f. Location (Street and Number or R	ural Route Number, City
Division of Vital Records, lalor Attending Physician: The law require	nours after neral Dire filled in l	Certification:	Suicide Could not be determined (Specify) restaurant		or Town, State) 5702 Martin Luther King Highway,	
Division of Vital !	4 hour		29a. Certifier			
the H	within 24 hours after death. To the Funeral Director:	Medical	one Medical Examiner: On the basis of examination and/or invited the basis of examination and or invited the basis of examinat	estigation, in my opinion, death occurred a	at the time, date and place, and due to the	ne cause(s)
To	To COT	Mec	29s. Signature and title of certifier	29c. License number	29d. Date signed (Mo	
			(O desclass of a)	O.C.M.E.	May 15, 2010	
٨	1	- 1	30. Name and address of person who completed cause of death (Item 23a)			
0	40		Laron Locke MD. Assistant Medical Examiner, 111	enn Street, Baltimore, MD 212	01	
	S	tate	31. Mayo dog handlar) Anna 32, Register's Statute			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ May 13 20°10 3:55 P M Laura S. Valda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Holy Cross Hospital Silver Spring Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Months Hours Jun. 8, 1920 Director Ukn 89 Bolivia Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20878 Bolivia | 2 McDonald Chapel Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1X Yes 2□No Specify: Bolivian White If Yes, Give Year or Dates 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pediatrics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Luis Escobar Sara Valda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Erdulfo Valda/Brother 2 McDonald Chapel Court, Gaithersburg, MD 20878 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Ft. Lincoln Crematory 5/24/10 4 Donation 5 Other (Specify) Brentwood, Maryland Signature of Funeral Service Licensee M0146 Simple Tribute 22. Name and Address of Facility 23a. Part 1/Inter/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Respitory Failure 1040 Rockville Pike, Rockville, MD 20852 Approximate Interval Between Onset and Death Physician. Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, Examine Due to for as a consequence of if any, leading to immedicause. Enter Underlying the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician dbe detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Zoster Meningitis 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? Yes 2 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: ည 1 Tes 1X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred After 1 X Natural injury 5 \square Pending Accident Investigation after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State)

24 hours a Funeral C To the within 2

> State Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of

Maria J Tayag,

2

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (tem 23a) (Type, Print)

32. Registrar's Signature

completed

MD 1500 Forest Glen Rd Silver Spring, MD 20910

**Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Dav. Year) 5/14/2010

29c. License number

D63579

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c County of Death Wled ent? Year If Under 24 Hrs 116 6. Sex 1 XM 2 F Social Security Number **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Hours (Month Day, Year Director N/A Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Me tical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 10d. Inside City Limits en GRAJE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21060 816 US A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No If Yes Give Specify: 3 Widowed 4 Divorced Specify Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 0 N/AN/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F P Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau na Kin 816 Glen Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 5/18/2010 Glen Burnie, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 0 12 Ridgley Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Trem X Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed? Yes 2 A No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 2 No 1 Yes 1 N Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours a 29a Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 00 30. Name and address of person who completed pause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

2001 _ 31. Date filed (Month, Day, Ye

2001 Medical Pkwy

Suzanne Rindfleisch

Annapolis, MD 21401

32. Re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0530 CM 2012 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death 40 0 If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. (Month, Day Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No runde 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21060 816 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ò þ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Black "natural", Specify. Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) N/A N/A 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) hakia Blvd 7816 Baltimore Mother thropolis 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 5/18/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. Annapolis, MD 21401 10 12 Ridgely Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ ntraven disease or condition Medical resulting in death) Examiner treme Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 2 No g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 1 ☐ Yes 2 ☐ No 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2 XNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 1 Natural Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 5 Pending 1 Yes 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month. Day, Year) kees of person who completed cause of death (Item 23a) (Type, Print) Annapolis, MD 21401 2001 Medical Pkwy Suzanne Rindfliesch

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bernard Warwick 11:374 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisburg UCOMICO If Under 24 Hrs 7. Age (In yrs. last birthday If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Hours Min. 09/09/1934 214-32-1259 Director Maryland Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Wicomico Maryland Salisbury 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 1825 Southmill Drive 21804 USA and Mental Hygiene, is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc Marine Corp Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give 21215-0036 1 Yes 2X No Specify: Specify: white 3 🗌 Widowed 4 🗌 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) sales retail Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Warwick Cleona Gates permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1825 Southmill Dr., Salisbury, MD 21804 Janet Warwick/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Salisbury Crematory 5/29/2010 Salisbury, MD 21. Signature of Funeral Service Lio ECTTOWN TIME THE Home Professional Association 501 Show Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ cordiomyo disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death Other (specify) 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Qid tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available cate has b ; page 2 sl autopsy prior to completion of cause of death? After this certificate 25. Was case referred to medica examiner? Be director. 26. Place of Death (Check only one) No မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Enpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending death. 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director:

Completed filled in by the 6 Could not be Suicide Place of Injury - At hor building, etc. (Specify) - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland state of Maryland ltems10a-10c,10e,SLU,	/ Department of Health and WCHD .05 . 24 . 10 Certificate of Death	Mental Hygiene	7759
Physic Me	cian/ dical	1. Decedent's Name (First, Middle, Last) Charles G. White		2. Date of Death Month Day Year 2010	3. Time of Death 0.327A M
The same of the sa	niner	4a. Facility Name (if not institution, give street and number) PININGULA ROGIONAL MEDILLE C	4b. City, Town, or Location of Dea	vey His	mic
Funer Direct	or	5. Social Security Number 213-62-4980 Usual Residence of Decedent 6. Sex 1 M 2 F 7. Age (In yrs. last	yrs. If Under 1 Year If Under 24 Hrs Months Days Hours Min		rthplace (State or Foreign outtry) Yland
Defiult Page 1 and 2 should be filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertall Hygiene. Mimportant: If time 72 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	Director	Maryland Wicomico Willar	Comport Pocation Folso 10f. Zip Code		10d. Inside City Limits 1 Yes 2 No
th with th ns 23a o must be	Funeral	587 THETHYOUR Rd. 34882 Cobbs Hill Rd.	21874	10g. Citizen of What C	ountry?
JUSO urs after dea ural", or iter I Examiner	ted by Fu	1 Never Married 2 XXMarried 1 Yes 2 X No	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 Yes 2 No Specify:	rto Rican, etc.) Black, Whi	
VIZIO-0030 within 72 hours after jiene. or than "natural", o	Completed		16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) Letail Manager	16b. Kind of Business Grocery Sto	
yland, Id be filed v Mental Hyg arked othe	To Be	17. Father's Name (First, Middle, Last) unknown		ame (First, Middle, Maiden Surname)	
i, INIAL) nd 2 shoule ealth and h m 27 is me		1	19b. Mailing Address (Street and Number or R 34882 Cobbs Hill Rd.,		ip Code)
Dalumore, bernit. Page 1 and Department of Hea mportant; If item any injury or othe		1 Burial 2 X Cremation 3 Removal from State cem	ce of Disposition (Name of netery, crematory or other place) Sbury Crematory 5 2	Date 20c. Location - City on 21 2010 Salisbury,	
permit. Departi	ouce.	21. Signature of Edneral Service Licens	Holloway Funeral F 501 Snow Hill Rd.,	Home P.A., Salisbury, Maryla	nd 21804
h sicial Medic Examine	al er	23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter the original cause (Disease or injury) Due to (or as a consequent cause (Disease or injury)	ice of):		Approximate Interval Between Onset and Death
the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The Inversal Director: After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit	/Medical Examiner				
he death certific y the attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1	eath 3 Ectopic pregnancy	23d. Date of de Month	elivery Day Year
requires that the de been signed by the should be detached	<u>a</u>	Part II. Other significant conditions contributing to death but not resulti	ing in the underlying cause given in Part I.	23e. Did tobacco use contribute t	o the cause of death? Probably 4 Unknown
Physician: The law requires rthis certificate has been signal director, page 2 should b	Completed	25. Was case referred to medical		autopsy prior to death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes	utopsy findings available completion of cause of
ding Physician: h. After this certific	cate: To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER	26. Place of Death (Ch. NOutpatient 3 □ DOA Other: 4 □ Nursing Bb. Time of injury at work? M ■ 1 □ Yes 2 □ No	Home 5 Residence 6 Other (Spe	cify)
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	al Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)		28f. Location (Street and Number or Re City or Town, State)	ural Route Number,
thin 24 hour thin 24 hour the Funer	Medical	29a. Certifier (Check (Check only one)) Certifying Physician: To the best of my knowledge only one) Certifying Physician: To the best of my knowledge only one only one only one one of the best of my knowledge only one	nd/or investigation, in my opinion, death occurred nowledge, death occurred at the time, date and p	d at the time, date and place, and due to the place, and due to the cause(s) and manner a	cause(s) and manner stated. s stated.
			29c. License number D D D 5 4 7	29d. Date signed (Mon.	
	state	30. Name and address of person who completed cause of death (Item 23	4.1201 St Suite	655 Sliphor	MD 2184
Regis		MAY 2 4 2010 Same J.	And I		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amended item#8 WCHD SLU 5 26 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gloria Leona Whittington Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death COMICO TEXINSULA SALB641 MediEN KAGIONAL 7. Age (In yrs. last birthday, If Under 1 Year If Under g. Birthplace (State or Foreign 8. Date of Birth **Funeral** MD Country) 1 □ M 2X F Months Days Hours Min Director 215-58-6081 59 Usual Residence of Decedent shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d Inside City Limits Director 1 Yes 2 X No Westover MD Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 29842 Fairmount Rd 21871 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify:Black Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Somerset County College (1-4 or 5+) Elementary/Seconday (0-12) Substitute Teacher Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Viola Cros∀ell Joseph Whittington 12a Informant's Wanz/Belationship (Type:/Psint) Curtis Whittington/Son Martha Justice/Sister 80 Yalipe Addres alrested Number Tust Burty Number Othor Own, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 5-27-2010 Marion Station, MD John Wesley Cem 21, Signature of Funeral Service L censee 22. Name and Address of Facility 917 W. Isabella St any Bennie Smith Salisbury, Funeral Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the dise Approximate Interval Between Onset and Death Immediate Cause (Final VENTRI CULAR FIRRIUMTIO Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DILATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine ITR the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) v the ε hed fo 9 🗌 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a Was an After this certificate has funeral director, page 2: autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1
Yes Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No | Director: / Accident A Investigation in 24 hou. the Funeral Dire. Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined cal 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 9 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one Signature and title of certif 29c. License number 29d. Date signed (Month. Day, Year) owk 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

EASTERN

00

SHORE

DRIVE STUSPING

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		,	1 - State of Maryland / Department / Departmen	artment of Health and M rtificate of Death		ene 0	7761
5	Physicia		1. Decedent's Name (First, Middle, Last)		2. Date of Death Month 05	Day 16 Year 10	3. Time of Death 533 M
	/Medic Examin		Pearline Williamson 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	- and
	Funeral Director		Fairfield Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 440-38-1925 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,	Anne Arui 9. Birthe Cour 1920 Okla	ndel lace (State or Foreign ahoma
			Usual Residence of Decedent		ec. 13	1920 071	anoma
	death with the Maryland ms 23e or 28e-f show rmust be notified at	2	10a. State 10b. County 10c. City, Town or Lo	ocation		1	0d. Inside City Limits 1 ☐ Yes 27 No
	the M	Directo	Maryland Anne Arundel Riva	10f. Zip Code	10	g. Citizen of What Cour	
	3e or			21140	"		
	death	Funerai	3009 Marlin Drive 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No-	14. Race - Americ Black, White,	an Indian,
36	hours after turel', or ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☎ No	1 ☐ Yes 2 ☐ No Specify:	nouri, otc.)	Specify:Blac	
5-0036	be filed within 72 hours after death with the Marylar all Hygiene. I all Hygiene. I other than "naturel", or litems 23e or 28e-1 show other than "naturel", or litems and the notified at event, the Medical Examiner must be notified at	ed b	X⊠Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Dece	dent's Usual Occupation	1	6b. Kind of Business/In-	
215	nin 72 n nai	Completed	(Specify only highest grade completed) (Give	kind of work done during most of workin DO NOT use retired)	ng '	ob. Kind of Edsiries with	dustry
2	filed within Hygiene. other than "	Com	12th 0	Janitoral		Hospital	
and	be file	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, M	aiden Sumame)	
aryla	should be nd Menta marked imatic ev	Ţo	Unobtainable 19a. Informant's Name/Relationship (Type, Print) 19b. Maili		ta A. W		Codel
<u>8</u>	s 1 and 2 should f Health and Mer item 27 Is marke other traumatic			ng Address (Street and Number or Rura		read Second	(Code)
อ์	s 1 ar if Heal item other		20a. Method of Disposition 20b. Place of Dispo	9 Marlin Dr. Ri position (Name of matory or other place)		0c. Location - City or To	own, State
altimore,	0 0			wn Cemetery 5/2	2/10 Ea	gletown,	Oklahoma
Bait	permit. Pag Department Importent: I any injury o once.		21. Signature of Funeral Service Licensee Warry 11, Seese MOS 83	2. Name and Address of Facility m Reese & Sons 21 West St. Ann	Mortua apolis,	rwá. ^P 2140	01
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death) a. Jumquene)			Onset and Death
	/Medical . Examiner		Due to (or as a consequence of):	1/. 1			1
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	Varieta le	rear	<u> </u>	years
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease of Houry that initiated events				year
760,	certificate be executed ding physician and use as the burial-transit		resulting in death) Last Due to (or as a consequence of):	+ 0.			
∞	cate b physic the b	dicai	a Coronary air	leng Visean	<u> </u>		year
Вох 6	eath certific attending pl for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregrent 23c. If yes, outcome of pregnancy			23d. Date of delive	arv
	00	iciar	in the past 12 months? 1 Vec 2 Prognant at time of death 5[☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
о. О	at the by th stache	hys	9 ☐ Unknown			1	
	w requires that the de been signed by the a should be detached f	by	Part II. Dther significant conditions contributing to death but not resulting in the under the substitution of the substitutio	ınderlying cause given in Part I.		acco use contribute to to	. /
Records,	2 8 2	Completed			24a. Was an autopsy perform	ed? prior to co	psy findings available mpletion of cause of
Vital	yslcian: The is certificate hidirector, page	Be C	25. Was case referred to medical examiner?	26. Place of Death			
<u>o</u>	Physic this cal	မှ	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			nce 6 □Other (Specif	iv)
on (ding l h. After funer	tion	27. Manner of Death 1	of 28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how	w injury occurred	
Division of	or Attending Phystcian: after death. Director: After this certifica in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		28f. Location (Str. City or Town,	eet and Number or Run State)	al Route Number,
	Hospitel 4 hours Funeral ely filled	edical Co	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal 2 Medical Examiner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, a need to the courre	and due to the ca ed at the time, da	use(s) and manner as s te and place, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month,	Day, Year)
			Hux Javis uno	D53111		05/17	12010
V)	13		30. Name and address of person who completed cause of death (Item 23a) (Type HVNL T, DAVIS 2007 TIDEWAT	Print)	APOLIS	, MD 214	101
	Sta Registr		31. Date filed (Month, Day, Year) 9 2010 32. Redistrar's Signature	fall COLONY, ANN.			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

3	\cap	1	0	2	- 1	-7	10	0
1			U		1	7	0	1
	100		-		- /	P	400	-

		For State Certificate of Death	morna, v,	Reg. N	ZUIU 10.	1102
Physiciar Medical Examin	n/	1. Decedent's Name (First, Middle,Last) David Bruce WEISMAN		2. Date of Death Month Da May 28, 2010		3. Time of Death 0515 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or L 13261 Mid Atlantic Blvd. Laurel	ocation of Death	,	4c. County of Death Prince George	
Funeral Director		5. Social Security Number 579 – 48 – 1778 6. Sex 1	If Under 24Hrs. Hours Min.	8. Date of Birth(M	1934 9. Bir 1934 Co	thplace (State or PPENNSY I Van puntry)
any	F	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
land f show	힐	Maryland Montgomery Takoma Park				1 X Yes 2 No
the Mary	Director	10e. Street and Number 7701 Takoma Avenue 10f. Zip Code 20912			ited State	
death with or items 2	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hisp If Yes, specify Cuban, 14. Yes 2 No	Mexican, Puerto F		White, etc.	ican Indian, Black,
rs after ural",	솔	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation		ork done	Specify: Wh	
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiente tent: If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.	ompleted	Elementary/Secondary (0-12) College (1-4 or 5+) 4 College (1-4 or 5+) Purchasing Ag	DO NOT use retire	ed)	Construct Company	•
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other tranmatic event, the Medical injury or other transmatic event, the Medical control of the	Be Con	17. Father's Name (First, Middle, Last) Harry Weisman	8.Mother's Name (Doroth	(First Middle, Maid y STombe		
213 hould b ad Men is marl		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street				
, MD und 2 sho salth and em 27 is raumati	-	Morelyn Levy Weisman, Wife 7701 Takoma Av 20a Method of Disposition (Name of cemi			.,	912 Town State
More Pages 1 a tent of He ant: If it		1 X Burial 2 Cremation 3 X Removal from State crematory or other place)	06/0		ic. Location - City or a Shington eterv	, DC
Baltimore, permit. Pages 1 at Department of He Important: If ite injury or other tr	4	4 Donation 5 Other Specify: Washington Hebrew 21. Signature of Figure 1 Service Licensee 22. Name and Address of 254 Carroll	of Facility Tor	chinsky	lebrew Fu	neral Nome 20012
Physician	\dashv	23a. Part) Enter the disease, or complications that caused the death. Do not enter the mode of dying, s (aiture. List only one cause on each line.			-	Approximate Interva Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovaso Due to (or as a consequence of):	cular dis	sease		Death
	۱,	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
sd isit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
be executed sician and nurial - trans	dical	XUNPENDED AMENDED 23a,27, per ME G904 6/28/10	TT			
that the death certificate be executed ned by the attending physician and detached for use as the bural - transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Pregnant at time of death 5 Other (Specify)	Ectopic pregnar		23d. Date of deliver Month I	y Day Year
P.O. B s that the d gned by the	ē	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I.			the cause of death? bably 4 Unknown
Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the rs after death. "Al Director: After this certificate has been signed by the funeral director, page 2 should be deach.	Completed			24a. Was an autopsy performed	prior to death?	utopsy findings available
II Re	ပ္ပ	25. Was case referred to medical 26.Place of	of Death (Check o		No 1 Y	es 2 No
Vita hysicia this ce	To B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA C	Other Nursing	g Home 5 Res	idence 6 🗸 Othe	r; Scene
ion of tending P eath. or: After the funera		(Month, Day, Year)	y at Work?	28d. Describe how	injury occurred	
Divisal or At turns after dura after dura liled in by	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office but (Specify)	ilding, etc.	28f. Location (Stree or Town, State		ural Route Number, City
	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, and manner stated.	e and place, and death occurred at	due to the cause(s) t the time, date and	and manner as state	ted. ne cause(s)
E S E S	Me	29b. Signature and title of certifier 29c. License			d. Date signed (Mo	onth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	1.E. 	M	lay 29, 2010	
		Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Ba	iltimore, MD 2	21201		
Sta Registr		31. Date filed (Month Day Year) 2010 32 Registrar's Signature				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 22:41 p.M 2018 Sarabeth Weiss May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 709 Boston Avenue Takoma Park 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth July 27, 1964 1 □ M 2 🛛 F washington. 577-90-9305 45 Director Yrs Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Takoma Park 1 Tes 2 X No Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 709 Boston Avenue 20912 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give ural", or iten I Examiner r 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene.
I other than " College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Teacher Education 7 is marked othe traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ည Mark Weiss Joan Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s t of Health If item 27 i or other tra Mark Weiss - Father 8902 McGregor Drive, Chevy Chase, Maryland 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Judean Memorial Grdns: 05/18/2010 Olney, Maryland 21. Signature of Funeral Service License Hines-Rinaldi Funeral Home, Inc 22. Name and Address of Facility M00209 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healt-failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) DR11 200 Medical Due to (or as a consequence of) Examiner Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed the burial-transit Due to (or as a consequence of) physician Physician/Medical the attending phase it IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year s been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page performed? Yes 2 No certificate 2 🗆 No 1 Tes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 □ No Other: 욘 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending work?
1 Yes hours after death. neral Director: Aft d filled in by the fur 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as a stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the Hosp within 24 ho To the Fune completed f (Check only one) Signature and title of certific 2010 Sha man Dima D00428

Registrar
DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

2101 Medical Park Drive,

#304, Silver Spring,

Maryland 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD,

Brecher,

Ira N.

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 18, Physician/ 2ัซี10 11:20 AM Otto Hans Willim Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Brooke Grove Nursing Home Sandy Spring Montgomery 8. Date of Birth (Month, Day, Year) 6, 1918 Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Hours Country) Austria **Director** 090-32-6644 91 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗌 Yes 2 😾 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 15115 Interlachen Drive, Apt. 626 United States 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2X No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: "natural", 3 Divorced 4 Divorced White Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert Willim Karoline Roth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 Iris Anderson/Daughter 2901 S. Leisure World Blvd. #337, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Date 2010 21, 1 Burial 2 5 Cather Specify) Metropolitan Crematory 4 🔲 Donatio Māÿ Alexandria, VA 21. Signatur uneral Service L 22. Name and Address of Facility Francis J. Collins Funeral Home, Incing, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MD 20904 Approximate Interval Between Onset and Death Immediate Cause (Final Physician KILATERAL PNEWMONTA URO SEPSIS AND I WEEK disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine trany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for se a consequence of attending physician and for use as the burial-tran that initiated events Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 4 Pregnant a Month Pregnant at time of death 1 Yes 2 No us certificate has been signed by director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ABUANCED PARKINSON 2 No 3 Probably 4 😾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Tes 2 🔲 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ပ္ 33700 MAY 05 2010

Registrar

State

MD 154 N. Artizan Street, Williamsport, MD 21795

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signat

Ted Eric Howe,
31. Date filed (Month, Day, Year)

21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Edna Mae Yinger Month May 2010 9:18 PM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death ter Frederick **Examiner** 4c. County of Death Frederick Citizens Nursing & Rehabilitation Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Oct. 7, 1925 9. Birthplace (State or Foreign **Funeral** 1 - M 2/X Hours Director 220-16-3204 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 ☐ No 10f. Zip Code 21702 10g. Citizen of What Country? ö er than "natural", or items 23a of the Medical Examiner must be 1900 Rosemont Ave. Funeral 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, rmed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: Specify:White ¾ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Decupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harold L. Wachter Blanche N. Moss permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 96, Keedysville, MD 21756 Paul S. Yinger, son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery June 2, 2010 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State Frederick, MD 4 Donation 5 Other (Specify) 21. Sign ²Keeney^a්anීම පිම්ප්රord PA Funeral Home M00255 106 East Church St., Frederick, MD 21701 tions that caused the death ause on each line. 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one o not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or i that initiated events the burial-transi Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No n signed by the atte Id be detached for Day Year 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 XiNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 D Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, deat courred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a 29d. Date signed (Month, Day, Year) au of death (Item 23a) (Type, Print) M.D., 300 West 9th St., Frederick, MD Robert L. Kaufmann/, 21701

DHMH 17 Rev 7/2009

215

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

10-04078 UN

Pleas

e:	lype of Print in Black indelible lilk.	Elistic All copies Are Legible.
	State of Maryland / Department of H	calth and Mental Hygiene
	State of Marviand / Department of n	ealth and Mental Hygiene

NK UNK	1- For State of Maryland / Department of Health and Certificate of Death	Reg. No.
Physician/	1. Decedent's Name (First Middle,Last)	2. Date of Death Month Day Year O146 have
tical Examine	Konald Anderson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or be	Way 29, 2010
	Harbor Hospital Baltimore	NA
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days	
ow any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Middle	2 River 10d. Inside City Limits 1 Yes 2 No
the Maryland t or 28a-f show tiffed at once. Director	10e. Street and Number 10f. Zip Code	21220 10g. Citizen of What Country?
1215-0036 d be filed within 72 hours after death with the Maryland fental Hygiene. sarked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once.	1 Never Married 2 Married Armed Forces? 1 Yes 2 No	panic Origin? (Specify Yes or No- , Mexican, Puerto Rican, etc.) Specify: 14. Race - American Indian, Black, White, etc. Specify: Specify:
72 hours afte n "natural", al Examiner efed by	or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Docupation	ion (Give kind of work done DO NOT use retired) 16b. Kind of Business/Industry
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natt e event, the Medical Exa	77.1 47.5 114.115.115.115.115.115.115.115.115.115.	18.Modner's Name (First, Middle, Maiden Surname) Tridonna Taylor
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street 19c. Street 19c. Street 19c. Street 19c. Mailing Address (Street 19c. Street t and Number or Rural Route Number, City or Town, State, Zip Code) 21212 UNSTANS 2 A Floor Baltimore, Ma.	
≒ % % ≒ ∄ l	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of centermatory or other place)	en 6/7/10 Battimore Maryland
	21. Signature of Funeral Service Licensee 22. Name and Address 3512 for 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying,	such as cardiac or respiratory arrest, shock, or heart Approximate Interval
Physician /Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Shotgun Wounds Due to (or as a consequence of):	Between Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
50, te be executed ysician and burial - transit	(Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of): d.	
8760, ificate be execut by physician and street burial - tra	UNPENDED AMENDED IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	23d. Date of delivery Ectopic pregnancy Month Day Year
the death certificate the death certificate by the attending phy ched for use as the least the l	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	niven in Part I 23e. Did tobacco use contribute to the cause of death?
cords, P.O. B law requires that the d has been signed by the 2 should be detached		1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available
tal Records cian: The law requi certificate has been ector, page 2 should	26 Place	autopsy prior to completion of cause of death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No
ician:	25. Was case referred to medical examiner? Hospital: Inpution 2 PR/Outpatient 3 DOA	e of Death (Check only one) Other ₄ Nursing Home 5 Residence 6 Other:
ing Ph	27 Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury	rry at Work? 28d. Describe how injury occurred Subject shot
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	1 Natural 5 Pending Investigation 2 Accident Suicide 6 Could not be determined Specify Local Street Natural Specify Local Street	4100 Pennington Avenue, Baltimore, MD
To the Hosp within 24 ho To the Func completely f	Certifying Physician: To the best of my knowledge, death occurred at the time, done) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.	n, death occurred at the time, date and place, and due to the cause(s)
	his his, nos	May 29, 2010
	30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	MD 21201
Sta		
Registr DHMH 17 Rev 1/200	ODIO O COTO /SOIT	OCME

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	1	1 - For State Registrar		(Certificate o				Reg. No	2016	17767
Physici Medi		1. Decedent's Name (First, Middle, Last, Audrey Merritt A						2. Date of De Month JUNE		y Year	3. Time of Death
Exami		^{4a.} Facility Name (if not institution, give s Morningside Assi	street and number) Stant Livir	ng	4b. City, Tow Hanc		on of Death		4c.	nne Aru	indel
Funeral Director				yrs. last birthd 34 Yr	Months Da		der 24 Hrs. s Min.	8. Date of Bir June ^{h, Ba}	th 14, 1992	5 Mar	rthplace (State or Foreign
Maryland 28a-f show otified at	Director	Usual Residence of Decedent 10a. State Maryland Anne Aru		c. City, Town o	up						10d. Inside City Limits 1 ☐ Yes 2 ☒No
with the is 23a or nust be n	Funeral D	10e. Street and Number PO Box 251			10f. Zip Coo 2079					tizen of What C ted Sta	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hatural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces 7, 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	in U.S.	13. Was Decedent of If Yes, specify C			ecify Yes or No- Rican, etc.)	- 1	14. Race - Am Black, Whi Specify: Wh	te, etc.
vithin 72 hor liene. er than "nat the Medica	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Seconday (0-12)		i (G	ecedent's Usual Oc Give kind of work do fe. DO NOT use retii Homema	ne during m ed)	ost of worki	ing		kind of Business wn Home	
be filed v fental Hyg irked othe	To Be	17. Father's Name (First, Middle, Last) Charles S. Schu	ltz					e (First, Middle, ae Marbi		,	
od 2 should salth and N n 27 is ma er trauma		19a. Informant's Name/Relationship (Тур Patricia Shipley	oe, Print) /Daughter	19b. N P. 0	Mailing Address (Str. 0. Box 25	et and Num 1,Jes	nber or Rura Sup, M	Aryland	r, City or , 207	Town, State, Z 94	ip Code)
Page 1 ar Trant of He tant: If iter jury or oth		20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ 6 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery,	Disposition (Name of crematory or other ic Cremat	olace) Ory	6/8/2		Gle:		e,Maryland
permit. Depart Import any inj		21. Signature of Funeral Service License	us								ral Home,Inc. and,21075
Fnysician/ Medical		23a. Part 1. Enter the disease, or composition shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ications that caused the e cause on each line. a. De Monday			lying, such	as cardiac c	or respiratory an	rest,		Approximate Interval Between Onset and Death
Examiner		Sequentially list conditions,	o. ————								
ufficate be executed tificate be executed ong physician and as the burial-trans t	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a co								
cate be e	Medical	L.	d								
e death certific the attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 Ectopic pregr 5 Other (specify	ancy				23d. Date of de Month	elivery Day Year
Attending Physician: The law requires that the death cer of actor. After this certificate has been signed by the attending the funeral director, page 2 should be detached for use	þ	Part II. Other significant conditions cor	ntributing to death but no	ot resulting in t	the underlying cause	given in Pa	art I.				o the cause of death? Probably 4 □ Unknown
The law reate has be page 2 sho	Completed									prior to death?	utopsy findings available completion of cause of
ysician: is certific director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:			Other:	eath (Check			J 17551	STED LIVING
tending Physical death.	Certificate: To	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 ∐ Inpatient 28a. Date of injury (Month, Day, Yea	28b. Tim	iry v	4 ∐ njury at ork? ☐ Yes 2		me_5 ∐ Resid 28d. Describe h		Other (Speny occurred	cify)
To the Hospital or Attendi within 24 hours after death To the Funeral Director; A completed filled in by the fi		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp.		, street, factory, offi	e		28f. Location (S City or Tow			ural Route Number,
he Hospi in 24 hou he Funer pleted fill	Medical	(Check 2 Medical Examina	cian: To the best of my ler: On the basis of exami	nation and/or in	nvestigation, in my or	inion, death	occurred at	the time, date a	and place	, and due to the	cause(s) and manner stated.
North Coal		29b. Signature and title of certifier When n	nd		-	nse numbe			Tin	te signed (Mont	2
		30. Name and address of derson who co		(Item 23a) (Typ	pe, Print)	nite	234	niee	Leysu	rtle .	21108
Sta Registr		31. Date filed (Month, Day, Year)	32. Register's S	Signature	1. Care	/					-11-3

Time of Death

0940 hrs

9. Birthplace (State or ForeignMaryland Country)

10d. Inside City Limits

1 Yes 2 X No

Approximate Interval

Between Onset and

Death

Year

Day

10-04196 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dean Paul Anderson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Year Medical Examine Dean Paul Anderson June 2, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3365 Hall Creek Lane Calvert 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Date of Birth (MM/DD/YYYY) **Funeral** Months Min. Davs Hours Director June 5, 1956 047-58-3297 53 1X M Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location : 23a or 28a-f show e notified at once. or 28a-f shov Owings Calvert 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3365 Hall Creek Lane 20736 USA Funera 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. Never Married 2 Married 2 X No Yes 4 X Divorced If Yes, Give Year Widowed Yes 2 X No specify: Specify: white "natural", <u>۾</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 William & Heintz manager and Mental Hygiene 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) ent of Health and Mental Hy ant: If item 27 is marked o or other tranmatic event, th Be Robert Henning Anderson Judith Anne Capen ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melissa Anderson/sister 1581 Laraway Lake Dr SE; Grand Rapids, MI 49546 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) Pages 1 Burial 2 Cremation 3 Removal from State X Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22 Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street rector Maryland 21201 Baltimore. l. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** e. List only one cause on each line /Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit death certificate be executed Physician/Medical attending physician or use as the burial UNPENDED **AMENDED** Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown hed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? \$ Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? certificate Yes 2 V No 25. Was case referred to medical 26.Place of Death (Check only one) To the Hospital or Attending Physician: Division of Vital Be Hospital: 1 Other 4 Inpatient ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene this 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: Natural Director: d in by the f 5 Yes 2 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year) O.C.M.E. June 3, 2010 111 Penn Street, Baltimore, MD 21201

2 👽 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

To the

State Registra

29b. Signature and title of certifier

Ana Rubio MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Margret Elinore Abernathy Month ам 3:05 June 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice If Under 24 Hrs. Hours Min. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗀 🛠 485-30-5846 Months Days Country) 79 Yrs Director 08/16/30 Towa Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sl any injury or other traumatic event, the Medical Examiner must be notified in Bristow VA Prince William 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral Kitt Court 20136 USA 10060 Woolen 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes Give 3 Nidowed 4 Divorced Year or Dates. Air Force 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) vuku Cukh. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Paul Flindt ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1604 Sailaway Court, Baltimore, MD 21221 DeLacy F. Main/ Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Final Journey Crem. 6/5/2010 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address PiFacility Cremation Services PO Box 1413, Baltimore, MD 21203 *Ddrota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ebushin disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause, Enter Ungerlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical **Hospital or Attending Physician**: The law requires that the death certificate be 24 hours after death. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death g Unknown Month Day Year 9 Unknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Minknown To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 Yes Yes 25. Was case referred to medica Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 **N**O 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence S Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Natural 2 🗌 No To the Hospital or Attendi within 24 hours after death. To the Funeral Director, A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print) DIN NOLVAT VES 31. Date filed (Month, Day, Year 32 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ **Honth** William George Bond Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Nov 10, 1910 Hours 400-22-1669 North Carolina Director 99 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Tyes 2 No Maryland Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code ō 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 7355 E. Furnace Branch Road 21060 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Baptist Minister Ith and Mental Hygien 27 is marked other the traumatic event, the Ministry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edward Warren Bond Cora Leary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. of Health Marvin Bond, Son 204 Greenwood Road Linthicum Heights, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 06/05/10 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Cremation Society Of Maryland, Inc 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ nou mont disease or condition resulting in death) Medical to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a co Examir or Attending Physician: The law requires that the death certificate be executed as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of). the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day Year should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate Yes 2 XN 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospital 2 N No Other: 1 🗌 Yes 1 Inpatient 2 28a. Date of injury ျှ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Natural Accident (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nurse Practioner: To the best of my knowledge, death ancumed at the time date and place, and due to the cause(s) and manner as status 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 (MY) s of person who completed cause of death (Item 23a) (Type, Print) 30 State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Wayne Bowen 30, 2010 11:17 P. S. May 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death 9210 Silver Sod Howard Columbia Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Months Days Hours Min. 1**x** x 2 □ F 213-42-6459 65 02-08-1945 Washington DC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b Counts 10d Inside City Limits 1 ☐ Yes 2 TNo Howard Columbia 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 9210 Silver Sod 21045 United States 12. Was Decedent Ever in U.S. Armed Forces? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status TYPES 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1964-1 ☐ Yes XXNo Specify Specify: 3 Widowed 4 Divorced 1968 White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Systems Analyst Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Gideon Thomas Bowen Doris Mildred Nones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pei Li - Wife 9210 Silver Sod, Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 06-05-2010 Glen Burnie, Maryland Atlantic Crematory 21. Signature of Funeral Service L 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP., Inc., 7250 Wash. Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 OCAMIGL INFAMILION 1 hour CUT disease or condition resulting in death)

Physician /Medical Examiner

> burial-trar physician at the burial

attending pt

certificate has been signed by the rector, page 2 should be detached

funeral director,

completely

this

After 1

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Be

ဥ

Exami

Physician/Medical

2

Completed

Be

Certification: To

Medical

MD

Funeral

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Evan incl. aust be notified at

65 Health a

Department of Health Important: If Item 27 any injury or other tronce.

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Sequentially list conditions if any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

IF FEMALE:

	Due to (or as a consequence of):	
b	Dies to (or es a conse juence of)	_
c	Due to (or as a consequence of):	
d		

23d. Date of delivery Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 4 Pregnant at time of death

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy 1 □ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

3 Ectopic pregnancy

5 Other (specify)

29a. Certifier
(Check only
one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ikers Are#300 3449 REDERICK

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State Registrar DHMH 17 Rev 1/2001

altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed s ofter decay. 24 hours within 2 To the

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#9perFH,G904,6/9/2010,WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Virginia Burk hardt Physician/ Month June 0320AM 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death County General Hospital Howara Columbia Howard 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sep 11, 9. Birthplace (State or Foreign **Funeral** Months Days Min Country) Hours 73 Yrs Director MD 212-34-9983 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at 10d. Inside City Limits Director 1 🗌 Yes 2 📉 No MD Howard Elkridge 5 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral 6374 Euclid Avenue 21075 United States 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Howard Co. Water Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other transment. 12 Dept Administrative Assist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Leroy Clayton Burnham, Sr. Beulah Florence Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Burkhardt / Husband 6374 Euclid Avenue Elkridge, MD 21075 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Jun O.S 4 Donation 5 Other (Specify) Beltsville, Maryland 2010 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Narce and Address of Facility Funeral Alternatives M01443 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death End Physician/ Obstructue rage chrome disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last burial-transit and the attending physician thed for use as the buria Uncontrolle a Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown should be detached for Month Dav Year Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 2 N 2 🗌 No Yes 1 🗌 Yes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: 2/X No ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗆 No Accident Investigation Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. сотрыете within 2 only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A1-19 500 Stand Bell 101 32. Registra State Registrar

10-04230 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Ihsan Bolat State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death Physician/ 3. Time of Death Month **Medical Examiner** 1808 hrs June 1, 2010 Dr. Ihsan Hamit Bolat 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours oreign Director Country) Turkey 095-34-3135 1 X M 84 Feb. 6, 1926 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits New s 23a or 28a-f show e notified at once. 1 Yes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Bernalillo <u> Albuquerque</u> Mexico Director 10e Street and Number 10f. Zip Code 10g, Citizen of What Country 5900-B Tierra North East 87111 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 Yes 2 X No 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: White Specify: 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical 21215-0036 5+Dermatologist Health Care 17, Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) event, Be Ibraham (nmn) Bolat Halide (nmn) Omer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD Ellen M. Bolat / wife 5900-B Tierra North East, Albuquerque, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date or other 1 X Byurial crematory or other place) Cremation 2 3 Highview Memorial Gdn 6/9/10 Fallston, Maryland Other Specif onation 22. Name and Address of Facility McComas Funeral Home, P.A. Broadway, Bel Air, Maryland ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a. Head and Neck injuries complicated by Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and tran Physician/Medical UNPENDED the attending physician ed for use as the burial AMENDED Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Year Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by t be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o 23e. Did tobacco use contribute to the cause of death? ģ Records, P. 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed' death? Yes 2 No 2 No 1 🗸 Yes 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be examiner? Hospital: 1 ✔ Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA this 1 Yes ို No After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Apr 1, 2010 Subject fell 0000 hrs Natural Pending 1 Yes 2 ✔ No death. 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) unknown, New York, NY

Division Director: To the Funeral

DHMH 17 Rev 1/2001

Medical

State Registrar

4 ___ Homicide

32. Registre s Sign

OCME

(Specify) Local Street

and manner stated

Assistant Medical Examiner

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c License number

O.C.M.E

29d. Date signed (Month, Day, Year)

June 4, 2010

Ana Rubio MD.

29b. Signature and title of certifier

determined

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JMne 1 Day 2010 ear 6:00 A Paul Bystrak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Czechoslovakia Funeral 081-32-7548 Hours Min. 1 M 2 F JuManth 2784, 1949 20 Director Usual Residence of Decedent 10b. County 10a State "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Carroll Manchester 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2918 Patricia Ct. 21102 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) United States Army Major Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic ever မ Judith Murbanek Stephan Bystrak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2918 Patricia Ct. Manchester, MD. 21102 Colleen Abbott - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Arlington Nat. Cem. Sept. 17,2010 Arlington, VA. 21. Signature of Funeral Ser ce Licens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD. 21102 . Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme di ite Cause (Final disea or condition Physician/ Due to (orus a consequence of): Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence 🍂 sician and burial-transit Due to (or as a consequence of): resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be eximin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month 1 ☐ Yes 2 € 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examplation and/or investigation, jorny opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier jormy opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death em 23a) (Type, Pro 31. Date filed (Month, Day, Year) Registrar's Signature State IUN 08 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month James L. Berge Medical June 2010 :10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 20 **Funeral** 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 ☑ M 2 □ F Months Hours Min. Country) 380-50-5141 65 Director Yrs. Minnesota Usual Residence of Decedent or 28a-f show notified at 10a. State death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Tes 2 No Montgomery Potomac ō 10e Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 11608 Lake Potomac Drive 20854 United States items 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces ō à 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: White "natural" Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 72 than, within Elementary/Seconday (0-12) College (1-4 or 5+) Hygiene. the Dentist Denta1 Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be file trent of Health and Mental H tant: If item 27 is marked of jury or other traumatic ever ဂ္ Harry Berge Dolores Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Lois Berge/Wife 11608 Lake Potomac Drive, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Parklawn Memorial Park 1 X Burial 2 Cremation 3 Removal from State June 8, 2010 4 ☐ Donation 5 ☐ Other (Specify) Rockville, Maryland 21. Signature of Funeral Service Licensee Pumphrey Funeral Home/ 22. Name and Address of Facility Robe Bethesda-Chevy Chase Bethesda, Maryland 2 Robert A. 7557 Wisconsin Avenue M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Colon Cancer with Metastasis to the liver Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ò Month Year Pregnant at time of death signed by the a d be detached f Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😾 Unknown Completed plnous been. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate ☐ Yes 2 🔀 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospice Inpatient examiner? ျှ 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) s after death.

I Director: After the in by the funera 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Kouarchou, m) 163748 Jocelyne June 2, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jocelyne T. Kouatchou, MD 6001 Muncaster Mill Road, Rockville, Maryland 20855 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 2010 1:15 une Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Director 1 Yes 2 ☐ No 10g. Citizen of What Country? LAMOUT DRI Completed by Funeral 207 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11, Marital Status Race - American Indian. Armed Forces?

1 Yes 2 If Yes, Give 1 Never Married 2 Married 2 No aryland 21215-0036 1 ☐ Yes 2 →No Specify: 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ERVILL 12 Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, M 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 📈 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 Donation 5 Other (Specify) Signature of Fineral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ HEMORPHAS disease or condition resulting in death) Medical Due to (or as a consequence of Examiner HUPSTER JUH Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed エチアリアニアラフのファ attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day 4 Pregnant a 9 Unknown Pregnant at time of death n signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş cate has been sig ; page 2 should b Completed INSUFFICIENS 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy STENOSIS certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 욘 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident 5 \square Pending 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director; A
completed filled in by the f Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and little 29c. License number ひらるひころ 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20170 てもし てらかい する人 7525 4 Red Entuck BRIVE

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year JUN 08 2010

ELAGO

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town er Location of Death 4c. County of Death tosoice finore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Føjeign 8. Date of Birth **Funeral** M 2 ▼ F Months Days Hours Min. 1 1777 Pay Year) 3 3 Maryland 76 Yrs Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore CO. Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9704 Kerrigan Court 21133 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after Specify: Black 1 Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Baltimore Museum Elementary/Seconday (0-12) College (1-4 or 5+) the of Art 12th Grade Executive Secretary traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Marjorie Jackson H. Epps 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9704 Kerrigan Ct., Randallstown, MD 21133 Madison Croskby(son) item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Inportant: If ite any injury or ot once. Andephemacory or other place) 1 Burial 2 Cremation 3 Removal from State 06/07/10 4 Donation 5 Other (Specify) 21. Signature of Fune al Service License HFullown AVE: , Euneral HOME 21217 JOSEPH. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dwing, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) myocardi Medical Due to (or is a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner n to (or as a nonsectionce of): Cause (Disease or iinjury burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) by the attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy☐ Pregnant at time of death 5 ☐ Other (specify) jo in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year detached 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has performed death? certificate Yes 2 No 2 No 1 🗌 Yes or Attending Physician: the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 10 2 No Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) ne and address of berson 1 20 Armory State 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lucille Anne Curtis June 2010 7:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Catered Living of Cockeysville Baltimore Cockeysville 5. Social Security Number **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 D M 2 Hours Min. (Month, Day, July 22 Director 212-50-0278 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at by Funeral Director 10d. Inside City Limits MD Baltimore Cockeysville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 10883 York Rd. 21030 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No Black. White, etc. 'natural", or i within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify: white Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) n/a Homemaker Own Home permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Edwin M. Barefoot Leona Anne Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Lisa A. Kratz/daughter 2642 Stockton Rd., Phoenix, MD 21131 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/9/10 Atlantic Crematory Glen Burnie, MD Signature of Funer 22. Name and Address of Facility
Lemmon Funeral
O W. Padonia Rd Lice Home of Dulaney Valley, Inc. Michael J. of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) *Pairs Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day Year Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 🗆 No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To 1 ☐ Yes 2 🖁 No Other: ALF 4 Nursing Home 5 Residence 6 Cher (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural Natural work? 1 🗆 Yes 2 🗆 No 5 Pending Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 037573 30. Name and address of person who completed use of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Tikell

MD

2835

32. Registrar's Signature

Jef

31. Date filed (Month, Day, Year)

Division of Vital

Baltinee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month June William Howard Calk Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month Day, Year)
Dec 6, 1930 7, Age (In yrs. last birthday) **Funeral** 1 ₺ M 2 □ F Days Hours Yrs Director 218-26-9477 79 Usual Residence of Decedent or 28a-f show notified at 10a. State 10h County 10c. City, Town or Location Director **Baltimore** MD 0 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the Medi al Examiner must be Funeral 21229 USA 612 Warwick 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? þ 1 Never Married 2 Married 1951-Maryland 21215-0036 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Specify: 1963 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traffic manager US Navv traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Washington Calk Lillian Katheran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Calk/spouse 612 Warwick Road; Baltimore, Maryland 21229 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 K Donation 5 Other (Specify) Funeral Service Licensee Rona Id S Wage State Anatomy Board; 655 W. Baltimore Street rector 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. GRD109ENIC Immediate Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events 1ZING FASCIITIS and -transit Exam resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ISCHEMIC CARDICTMU OPATHU 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 욘

Division of Vital Records, P.O. Box 68760	09
To the Hospital or Attending Physician: The law requires that the death certificate be ex	ite be ex
within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial.	hysician the burial

Approximate Interval Between Onset and Death 23d. Date of delivery Dav 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 2 🗌 No 1 🗌 Yes examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 405PICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death

1 Natural
2 Accident
3 Suicide 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 \(\subseteq \text{Yes} \quad 2 \subseteq \text{No} \) 5 \square Pending injury Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JUNE 3, 2016 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMERE, MD 2,204 6701 N CHARLES ST, SUITE 4105 DANIEUE DOBERMAN, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature **ORIGINAL**

3. Time of Death

РМ

4:50

9. Birthplace (State or Foreign

10d. Inside City Limits

1 → Yes 2 No

Mary Land

2ď 10

Black, White, etc

white

State Registrar

Certificate:

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kathryn C. Duev June 20 ľ 0° 10:35 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 707 Maiden Choice Lane Lane Apt.8221 Catonsville Baltimore Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days May 17, 216-80-4530 1 ☐ M 2🏋 F 101 Director °1′909 MaryTand Usual Residence of Decedent 23a or 28a-f show 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 10c. City. Town or Location MD Baltimore Catonsville 1 🗆 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. Funeral 707 Maiden Choice Lane Apt. 8221 21228 or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Ş 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: "natural", 3 Widowed 4 ☐ Divorced Completed Specify: white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Home Maker permit. Page 1 and 2 should be filed wir Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, til once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Hampton Cox Kathryn Josephine Mudd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph G. Duey, Son 5039 Jericho Road, Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 06-08-2010 Woodlawn, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or con plications that caus of the death. D I not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List of yone cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 205 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year g Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural
2 Accident
3 Suicide s after death Director: A d in by the f Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completed filled in Medica 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

31. Date Ned (Month, Day,

ress of person who completed cause of death (Item 23a) (Type, Print)

030989

Maiden Choice Ln

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

: <u></u>			1 - For State Registrar	State of I	Marylar		artmer rtificat			ınd M		giene () Reg. No.	10	17781	
	Dhysiai	665 h	1. Decedent's Name (First, Middle, Last)									ath Day	Year	3. Time of Death	h
	Physicia //		D.L.	Doane							06	03	2010		M
12	Examin		4a. Facility Name (If not institution	. 3			4b. City,	Town, or	Location of	f Death		4c. County of Death			
45	April 1	100 m	Genesis Eldercare Severna Park				Severna Park If Under 1 Year If Under 24 Hrs. 8, Date of B					Anne Arundel			
	Funeral		5. Social Security Number	6. Sex 7. 1 XM 2 ☐ F		83 Yrs.	Months Months		Hours 2	Min.	8. Date of Bir (Month, Da	ay, Year)	9. Birth	nplace (State or Fore	∍ign
n _e :	Director		227-36-5663 Usual Residence of Decedent			U) 118.					03-23-	-1927		VA	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depărunent of Health and Mental Hyglene. Important: If Item 27 is marked other than "nature!", or Items 23s or 28a-f show appringury or other traumatic event, the Madical Extinition maint be notified at another.	Funeral Director	10a. State 10b. County	,	10c. Ci	ty, Town or Lo	ocation							10d. Inside City Lim	nits
			MD Anne Arundel Glen Burnie											1 □ Yes 2 1	No
			10e. Street and Number 10f. Zip Code									10g. Citizen	of What Co	untry?	
			324 Ferndale Road 21061										U.S.A	-	
		lera	11. Marital Status	12. Was Decede	ent Ever in L	J.S. 13.			spanic Orig	in? (Spe	crfy Yes or No Rican, etc.)	o- 14. F	Race - Ame	ncan Indian,	
9		Ē	1 ☐ Never Married 2 🎇 Mar	ried 1 1 Yes 2 If Yes, Give			If Yes, spe			, Puerto I	Hican, etc.)		Black, White	e, etc.	
8		d by	3 Widowed 4 Divorced	Year or Date	s:		IL Yes	2E3 NO	Specify:			Spe	cify: Wh	ite	
5	72 h	etec	15. Deceder (Specify only highe	nt's Education est grade completed)		(Give	dent's Usu	nk done d	luring most	of workii	ng	16b. Kind o	f Business/l	ndustry	
21	ithin Per Mar	To Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)				DO NOT use retired)					MD Shipbuilding &			
2	12 should be filed w h and Mental Hygier 7 le marked other th traumatic event, Illi		9 Pipe Fitter							/m	Drydock				
n n			17. Father's Name (First, Middle,								(First, Middle	, Maiden Sun			
3			Arthur G.	Doane						ttie		Wyrick			
Maryland 21215-0036			19a. Informant's Name/Relations							r or Rura		er, City or To			
	1 and 1ealth im 2 ther t		Mrs. Helen Doa:	ne / Wife	20h		Fern			D	GLen E	Burnie, 20c. Locatio		21061	
Ö	M Ital		1 Durial 2 Cremation	3 □Removal from Sta		Place of Dispo cemetery, cre							-		
ij	permit. Pa Departmen Important: any injury		4 Donation 5 Other (S	the state of the s	GL	en Have								ie, MD	
Baltimore,			21. Signature of Funeral Service	Shirt !	MOIL	79 5	2. Name ai	eton	Funer	/1 2r	nd Aven Crema	ue SW tion S	Glen ervic	Burnie, l es, PA	MD
.O. Box 68760, <	The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or relation to the cause on each line. a										Approximate interval Between Onset and Death	
			IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	n 2 ☐ Feta tattime of d	ancy al death 3[⊒Ectopic p □ Other (s)					23d.	Date of deli Month	ivery Day Year	
S,		by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown				
Vital Record		Completed									24a. Was an 24b. Were autopsy findings				
Re	he la e has ige 2										autopsy prior to completion of cause performed?			completion of cause	
a	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certific ely filled in by the funeral director,	e C	25. Was case referred to medical		1 Yes 2 No										
		00	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Other: 4										-
ō); Το	27. Manner of Death	28a. Date of	28a. Date of Injury (Month, Day Year) 28b. Time of Injury						28d. Describe how injury occurred			sny)	
o		ig I	1 ♣ Aatural 5 Pendii 2 Accident invest	ng (Month, igation				Work? 1 ☐ Yes 2 ☐ N		No					
Division		Certification;	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	ot be						28f. Location (Street and Number or Rural Route Number, City or Town, State)				
		Medical C										taled to the cause(s)			
	To the within 2. To the complet		29b. Signature and title of certifier 29c. License number 1) 31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13c. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13c. Registrat's Signature 13c. Registrat's Signature 13c. Registrat's Signature 13c. Registrat's Signature							29d. Date signed (Month, Day, Year)					
			1 /sm ('well	llens			031136			JUNE 4.			2010	
•	1111		30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type.	, Print)	- 0					11.		
	711		BRIAN C.	WALLACE	, mid	900	5 KI	CBR	100	RD.	BACT	MORE	s, and	1 21236	
	Sta Registr		31. Date filed (Month, Day, Year	N 0 8 2010	istra's Sign	ature 8.	ba	Made	,)	•		1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20 10ar Jr. June Diehl 2324 MON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Mospital Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) April 4, 1951 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral 212-52-8344 Months Days Hours Min Penn. 1 XM 2 ☐ F 59 Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits Maryland Carroll 1 ☐ Yes 2 No Director Mampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4158 Double Tree Lane 21074 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Xes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married 1 ☐ Yes 2 🛣 No If Yes 1970 - 1973 Specify þ Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mechanical Engineer Elementary/Secondary (0-12) College (1-4or 5+) Risk Consultant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myron Herbert Diehl, Sr. Elda Herman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanne M. Diehl - wife 4158 Double Tree Lane, Hampstead, MD. 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 ☐ Removal from State Greenmount Church Cem. June 7,2010 Greenmount, MD. 4 ☐ Donation 5 ☐ Other (Specify) re of Full tal ervice I 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 3296 Charmil Dr. Manchester, MD. 21102 Enter the disease, or complications that caused the death. ock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest. Im be liate Cause (Final **Physician** MINULES disease or condition resulting in death) /Medical Due to (a a consequence of) Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

attending physician and for use as the burial-trar signed by t certificate has be rector, page 2 sl this certific al director,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'm Madical Examinar must be notified at

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
completely filled in by the

State Registrar

title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 🗆 Yes

2 No

The desired at the time, date and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hampslead, MD A. Rocha 4231 Northwoods Trail MiD Domingo 31. Date filed (Month. Day, Year)

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

> 2. Registrar's Signature acks

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 5^{Day} 201[°]0 2:44 Рм Constance Hartman Demaree Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 7. Age (In vrs. last birthdav) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Hours Min. (Month, Day, Ye September 9 Pennsylvania Director 219-36-9360 1922 87 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" any injury or other traumatic events. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Chevy Chase Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Leland Court 20815 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: 3 🕅 Widowed 4 🗆 Divorced If Yes. Give White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Education English Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Livingston Hartman Naomi Lucille Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Portland, OR 97219 13363 SW Iron Mountain Blvd., <u>Jean Demaree-</u>Roth / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) June 17,2010 Rockville, Maryland Parklawn Memorial Park 21. Signature of Funeral Service Licensee Robert A. Fumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, disease or condition resulting in death) Left Middle Cerebral Artery (Hemorrhage Infarct) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence offi that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death
Unknown Month Day Year 5 Other (specify) cate has been signed by the a page 2 should be detached? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵. þ Hospital or Attending Physician: The law requires Atrial Fibrillation Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Coronary Artery Disease certificate has autopsy performed? Yes 2X No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA After this filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation Director: Constance 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 6/5/10 SUDANHAN SWA

20V

2

S

Registrar DHMH 17 Rev 7/2009

State

Sudarshan Siva, M.D. 8600 Old Georgetown Road, Bethesda, Maryland 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

1065312

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9.<u>2010</u> Physician/ Month Anna Margaret Engel 3:30A 19 Mav Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Towson <u> Manor Care</u> 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Months Davs Hours Min. Country) Director 201-38-3830 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Baltimore Maryland Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 U.S.A. 502 West Joppa Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna M. Hoellein Fred P. Anders 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $73 e^{-/4}$ Baltimore, I <u> Caroline M.Bordley</u> 502West Joppa Road, Towson, Maryland 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Ty☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SouthsideCemetery 5-24-10 Pittsburgh, PA. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A michae 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Ons, t n Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Du⊨/t/ (or as a consequence of): Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and that initiated events Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) is certificate has been signed by the director, page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an after death.

Director: After this certificate has I autopsy 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #26, per verbal G904 678/10 TT State of Maryland Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 20010 June 7:00 A M Howard Delmer Eskew Medical 4b. City, Town, or Location of Death Street 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Harford 3628 Conowingo Rd. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 728/1965 Mary land Director 215-80-7734 45 Usual Residence of Decedent 28a-f shov ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10d Inside City Limits Director Aberdeen Harford MD 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21001 200 Engle Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: SpecifyWhite If Yes Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 0 Heavy Equipment Operator Construction Be 18. Mother's Name (First, Middle, Maiden Surname)
Wanda Gibson 17. Father's Name (First, Middle, Last) Cloyd Lee Eskew permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic v 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Engle Ave, Aberdeen, MD 21001 Wanda West / Mother 20a. Method of Disposition
1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, Date cemetery, crematory or other place)
.A. Ferris & Co. 6/11/2010 5 ☐ Other (Specify) R.A. 4 Donation <u>Pennsylvania</u> 21. Signature rring-Cargo Funeral Home, P 3 S. Parke St, Aberdeen, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Pregnant at time of death Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an i 24 hours after death.

• Funeral Director, After this certificate has the Funeral director, page 2 s 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Grandmother's
Other (SpecifyResidence 1 ☐ Yes 2 🌡 No Other: 4 Nursing Home မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) June 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gustavo Ulysses Flores State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last 2. Date of Death Physician/ 3. Time of Death Gustavo Ulysses Flores Month **Medical Examiner** 0948 hrs June 1, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3334 Buehler Court Olney Montgomery 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY 9. 8irthplace (State or Foreign Country) Months Days Director 215-74-1980 47 Hours Min. 03/4/1963 Yrs Usual Residence of Decedent 10a State Ob County 10c. City, Town or Location 10d. Inside City Limits MD Montgomery 01ney 1 Yes 2 No or 28a-f show or items 23a or 28a-f shormust be notified at once. Directo 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3344 Buehler Court 20832 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XNever Married 2 Married White, etc. Yes 2 X No Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", on injury or other traumatic event, the Medical Examiner in injury or other traumatic event, the Medical Examiner in Specify: White 3 Widowed 1XX Yes 2 No specify: Mexican 4 Divorced If Yes, Give Year Ś 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of 8usiness/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Professional Athlete 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Luis Gustavo Flores Natividad Armenta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11213 Troy Rd. Bethesda, MD 20852 Natividad A Flores, mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 8urial 2 X Cremation 3 Removal from State 6/7/2010 Chesapeake Crematory Beltsville, MD Donation 5 Other Specify 22. Name and Address of Facility Rapp Funeral & Cremation Svcs. faire of Funeral Service License 933 Gist Ave. Silver Spring, MD 20910 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line 8 etween Onset and /Medical Mixed drug intoxication(Oxycodone and diazepam) Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27,28a-f,per ME g905 7/22/10 TT X UNPENDED attending physician or use as the burial -Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Year Day past 12 months? Pregnant at time of death 5 Other (Specify) ned by the atter 1 Yes 2 No 9 Unknown 9 Unknown signed by the bedeache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed certificate has been rector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical director, of Vital 26.Place of Death (Check only one) Be examiner? Other 4 Nursing Home 5 Residence 6 ✓ Other: Scene Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes ဍ No funeral After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural Division 1 Yes 2 No Pending To the Funeral Director: Fd 6/1/10 Fd 0940 hr 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State 3334 Buenler Cl. 1010) 3 Suicide Could not be determined (Specify) residence 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E June 2, 2010 30. Name and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Štreet, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Year Force 22:34 M barbara June 2010 Ann 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 F 61 219-50-4173 Yrs TN08/29/1948 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore 1 X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country 10f Zip-Code 2118 Moyer Street 21231 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 XNo White Specify Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Commercial Artist Advertising 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sames Willard Gibson Ruby Mae Gibbs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Lynn Brown / Daughter 1417 Barrett Road, Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Final Journey Crem. 6/5/2010 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 21. Signature of Funeral Service Licensee Derota Marshall - Marshall Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final distructive disease or condition resulting in death) a. Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to fol as a consequence on resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 ☑No 1 Yes 2 400 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home Hospital 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed burial-transit and Box 68760, attending physician the as nse. Division of Vital Records, P.O. the signed by page 2 should be certificate has or Attending Physician; filled in by the funeral director, Director: After this death. after

Physician

Examiner

Funeral

Director

28a-f show

ö

or items 23a

'natural",

and Mental Hygiene.

Department of Health ar Important: If Item 27 is any injury or other trau

Physician

/Medical

filed within 72 hours after death

Pages 1 and 2 should be

Saltimore, Maryland 21215-0036

injury or other traumatic event, the Medical Examiner must be notified

Director

Funeral

<u>ک</u>

Completed

Be

ပ္

Examiner

Physician/Medical

ģ

Completed

Be

၉

Certification:

Medical

2 Accident

4 Homicide

3 Suicide

29a. Certifier

/Medical

within 24 hours a

To the Funeral D To the Hospital

(check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D RES 000 2010 June 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Narla venkato 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Re

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 🗌 Yes

2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Injury

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

State Registrar

Pending investigation

Could not be determined

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Amend Item 31 per dvr., g904,06/08/2010dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 3 Month Year 9:29 PM Physician/ harlott FISHMAN 06 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner alt If Under 1 Year Birthplace (State or Foreign Country) If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. Months Hours 1/25/1929 MD 217-22-1117 81 **Director** Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location **Funeral Director** must be notified 1**X**☐ Yes 2 ☐ No N/A BALTIMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 23a 21209 USA 6214B GREEN MEADOW PKWY Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian, ıral", or iten I Examiner n Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE If Yes, Give Year or Dates 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ **EDUCATION** PRINCIPAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ALPERT HILDA MORRIS FISHMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 WELLSPRING CIRCLE, OWINGS MILLS, MD STEVEN KELLMAN/COUSIN Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State BNAI JACOB CONG. 06/07/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 22. Name and Address of Facility SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE, INC. 21208 21. Signature of Funeral Service Licensee MD Acott 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Examiner Due to lor as a sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral o 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State IIIN 08 Ole Registrar

DHMH 17 Rev 7/2009

/Medical Examiner P.O. Box 68760, or Vital Records,

death certificate be executed burial-transi physician the as use for ed by the a signed b d be deta page 2 certificate funeral director this After Hospital or Attending death. within 24 hours after death

To the Funeral Director:
completely filled in by the

Physician

/Medical

Examiner

Funeral

Director

"natural", or Items 23a or 28a-f show dical Examiner must be notified at

other traumatic event, the Medical

s 1 and 2 should be filed within if Health and Mental Hygiene.

Pages 1 nent of H int: If Ite

permit. Page Department o Important: If any Injury or once.

Physician

72 hours after

アフトヤ

Director

Funeral

Completed by

Be

Examiner

Physician/Medical

þ

Completed

Be

ဥ

Certification:

25. Was case referred to medical examiner? 1 ☐ Yes 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

29c. License number D69540 29d. Date signed (Month, Day, Year) 6 6 2010.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jigan 8813 was ham woods 32. Registrar's Signature 31. Date filed (Month, Pay, Year)

Suit 204 Parkville MD 21234.

State

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Helen Freeburger Α. 2010 12:30 A June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 351 Sturtons Lane Pasadena Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 6. Sex 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days 1 □ M 2 □XF 216-07-9566 96 December 22, 1913 Maryland Director Usual Residence of Decedent 28a-f show be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Examiner must be notified 1 Yes 2 X No Maryland Anne Arundel Pasadena 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 351 Sturtons Lane 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. or Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) **Housewife** Own Home 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental I marked o ဂ |Blaize Mazan Catherine Kuta permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 351 Sturtons Lane, Pasadena, Maryland 21122 Janet Cogliano Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June ^D8 1 🎇 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place)
Stanislase Cem. 2010 Baltimore, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Connelly Funeral Home Of 7110 Sollers Point Road, Dundalk, P. A Dundalk, Md. 21222 23a. Part 1. Enter the disease or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on, ach line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year 5 Other (specify) Day g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No Yes 2. No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death

To the Funeral Director: / ☐ Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8 Dales Khele Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

TVARAM

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh e904 6-9-10 yt.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day William Η. 2010 Gundry June 1:35am Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Brinton Woods Healthcare Sykesville Carrol1 5. Social Security Number 2120-20-7653 Sex 1X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min 01-07-1924 Mary Tand Director 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hiptry or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carrol1 Maryland Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2101 Don Ave. 21157 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc þ 1 Never Married 2 Married ^{2 □ No}1943-Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: White If Yes, Give 3 ₺ Widowed 4 □ Divorced Completed Year or Dates 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Salesman Home Improvement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 William P. Gundry Isobelle Hi11 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia G. Dobry 2101 Don Ave. Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 □ Cremation 3 □ Removal from State Garrison Forst Vet. 6-9-2010 Owings Mills, MD 4 Donation 5 Other (Specify) of Funeral. rvice Licensee 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstown, MD 21136 Wayne Osterling 23a. Fart 1. Enter the c shock, or heart fa ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, re. List only one cause on each hise. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No signed by the atte Month Day Year Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 24 hours after death.

Funeral Director: After this certificate 2 - No 1 Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ဂ္ 1 🗌 Yes 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

within 2. State

> Registrar DHMH 17 Rev 7/2009

(Check

only one 29b. Signature and title of certific

31. Date filed (Month, Day, Year,

SILLES

and address of person who completed cause of death (Item 23a) (Type, Print)

(URNS

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying More Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20806

29d. Date signed (Month, Day, Year)

2010

21131

Herman Grumbach, Jr.

		1- For State Registrar				Certi	ficate of	f Death					Reg. N	o.		
Physiciar Medical Examin	1/	1. Decedent's Name (First	,	•	hac	h T	~				- 1	Date of De Month	Day	y Year		3. Time of Death 0612 hrs
Wedical Examin	G.	Herman 4a. Facility Name (if not i	Lee			h, J		4b. City, Towr	n, or Lo	ocation of		June 6,		4c. County of	f Death	
	H	Upper Chesape			,			Bel Air	, –					Harford		
Funeral	7	5. Social Security Number	er 6.	Sex	7. Age	(In yrs. last	t birthday)	If Under 1	_	If Under				M/DD/YYYY)	Foreig	thplace (State or
Director	1	216.80.624	13 1	M _M 2 F	4	9	Yrs		Days	Hours	Min.	10.2	9.1	960	Co	un iM) D
'n	-	Usual Residence of Dece 10a. State 10b.	edent County		1	Inc City To	own or Locat	ion								10d. Inside City Limits
1 00 M 31			arfoi	rd			ewood									1 Yes 2 No
ne Maryland or 28a-f show any fied at once.	황	10e. Street and Number						10f. Zip Cod	ie				10g. C	itizen of Wha	at Cour	ntry?
he Ma 1 or 28	Director	1201 Hall	Lsti	reet				2104	0				_	S.A.		
with t	ᇹ	11. Marital Status		12. Was De		ver in U.S.		s Decedent of					No-			can Indian, Black,
death or iter must	Funeral	1 Never Married 2		1 Yes	2	No	If Y	es, specify Cu	ıban, r	Mexican, P	uerto Ri	can, etc.)		White,		
s after	잙			ed If Yes, Give Ye or Dates:		1.		Yes 2					[40]	Specify: V		
hour "natu	Completed	15. Decedent's Education Elementary/Secondary		College (it's Usual Occi ost of working					160	, Kind of Bus	iness/I	ndustry
36 thin 72 than than	릵	12	(0 12)	oonege (Plumk	er					E	Blue D	ot	
5-06 ed wij	5	17. Father's Name (First,	Middle, La	st)					18	3.Mother's	Name (F	irst, Middle	, Maide	en Surname)		
121 i be fil ental F arked	å			cumbach	1, S	r.								butte		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.] د	19a. Informant's Name/Ro						Address (S								
mnd 2 (ealth tem 2' traum	ŀ	Merle Hec 20a. Method of Disposition		1/Siste	er	20b. Pla	5408 ace of Dispos	ition (Name of	ge f ceme	Roa etery,	a,	Whit Date	e M	Location - 0	, M City or	D 21162 Town, State
nore	1	1 Burial 2 Cr	emation	3 Removal f	rom Stat	_ cre	matory or otl	ner place)								le, MD
Iting nit. Partmer artmer ortan	ŀ	4 Donation 5 C	Other Speci Service Lic	<u> </u>	a 1/3		_									
Balt permit. Depart Import	1	Lundy Du	· Ri	tte. P	014	43	87	717 Gr	-00	n Da	AFA etu	/Ste res	pne Dr	PAlt	-О ГО	hrmann,PA
Physician	1	23a. Part I. Enter the dise failure. List only one			caused t	he death. D										Approximate Interval Between Onset and
/M. dical Examiner	1	Immediate Cause (Final	disease	a. Hypertens	ive Ath	eroscler	otic Cardi	ovascular	Dise	ase						Death
	1	or condition resulting in c	leath)	Due to (or as	a consec	quence of):										
	힐	Sequentially list condition if any, leading to immedia	ate	Due to (or as	a consec	quence of):										
	Examine	cause. Enter Underlying (Disease or injury that ini	tiated	Due to (or as	2 000000	mence of:										
ansit	֡֡֟֡֟֡֟֡֡֡֡֡֡֡֡֡֡	events resulting in death		d.	a consec	puerice or).										ļ
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medical	UNPENDED		AMENDED												
8760, tificate be ng physici	Ĭ,	IF FEMALE:	ant in the			e of pregna							2	23d. Date of d	-	
68 certifi nding ise as 1	igi.	23b. Was decedent pregn past 12 months?	ant in the	1 Live		me of death	2 Fe		3	Ectopic p	regnanc	У	-	Month		ay Year
Box 68 e death certified for use a	<u>š</u>	1 Yes 2 No 9	Unkno				5 [_] Ot	her (Specify)								
, P.O. Box 6(res that the death cert signed by the attendit be detached for use a		Part II. Other significant	condition	s contributing t	o death	but not resu	ulting in the u	nderlying cau	se give	en in Part	l.					the cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the start death. The law requires that the start from the law been signed by all Director. After this certificate has been signed by the funeral director, page 2 should be detach.	힣			- -						-	_		es 2			
cords, law requir has been s											_		opsy	pr.	ior to c	topsy findings available ompletion of cause of
Rec The la	Completed											1 Yes	formed 2		ath? ✔ Ye	s 2 No
Vital Recysician: The Libis certificate I	Re	25. Was case referred to examiner?	medical	Hospital: 1						Death (Cl					1	
F Vi Physic arthis	<u> </u>	1 ✓ Yes 2	No	28a. Date			R/Outpatient 8b. Time of I			ther ₄ N		lome 5		dence 6	Other	:
Division of pipital or Attending Phous after death ours after death filled in by the funeral	<u></u>	27. Manner of Death 1 ✓ Natural 5	Pending	(Mont	h, Day,Yea	ar)	ob. Time of it	′′ I _		s 2 N		u. Describ	5110#1	rijary occurre	ч	
isio	Certification:	2 Accident	Investig	ation	ce of Inju	ry - At hom	e, farm, stree	et, factory, offic	ce buil	ding, etc.	28	f. Location	(Street	and Number	or Ru	ral Route Number, City
ital or		3 Suicide 6 Homicide	Could not determine)							or Town,	State)			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certif		ician: To the be												
To the Hos within 24 h To the Fur completely	Medical			ner:On the basis and manner:		ination and	or investigat	ion, in my opir	nion, d	leath occu	rred at th	e time, dat				
	Ξ	29b. Signature and title o	f certifier		n			29c. Lic								oth, Day, Year)
			()	M. 7	A-				C.M.	.C.			Ju	ne 6, 201	U	
81		Name and address of Jack Titus MD.		io completed &au y Chief Medi			•	n Street, E	Baltin	nore, MI	D 2120)1				
Sta	te	31 Date filed (Month, Da	v Year)			Signature				-,						
Registr		JUN 082	2010	General	, ,	1	0, W. S								-	CARC
DHMH 17 Rev 1/200	01			,	10	190	ORIGINA	L							U	CME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of	f Marylan		artment tificate			and M	,	•	2010	1 7	703
			Hegistrar Decedent's Name (First, Middle, Las	st)		06/	incate	UID	Catri		2. Date of De	Reg. N	lo.	3. Time of	Dooth
	Physicia Medic		Genevieve Lit	win Gra	u						Month June		2010 Year	5:10	A M
1	Examir	_	4a. Facility Name (if not institution, give			-	4b. City, To	wn, or	Location of		- Cane	Ť	c. County of Death	13.10	Α
-			Gilchrist Hos	pice			To	wsoi	n				Baltimor	e	
	Funeral		5. Social Security Number 6. S	ex □ M 2 🖾 F	7. Age (In yrs. la		If Under 1 Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	th	9. Birth	place (State or	r Foreign
	Director		100-20-2036 Superior	LIWI Z LON F	88	3 Yrs.	Monand		riours	IVIIII.	Sept. 2	22,	1921 New	York	
	land show dat	5	10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside Cit	tv Limits
	Maryla 28a-f s otified	ect	Maryland Howard			Columb:	ia							1 🗆 Yes	-
	or 28	اقًا	10e. Street and Number			JOT GIND.	10f. Zip C	ode				10g. C	Ditizen of What Cou	ntry?	_
	s after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at	Funeral Director	6336 Cedar La	ne #110			2	1044	, +			U	ISA		
	death item		11. Marital Status	12. Was Deced		S. 13. \				gin? (Spec	cify Yes or No- Rican, etc.)	_	14. Race - Ameri		
36	after or ramir	۵	1 Never Married 2 Married	1 Yes	2 X No	- 1	Yes 2				iicaii, etc.)		Black, White, Specify: Whi		
8	2 hours aft "natural", edi: al Exar	Completed	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dat	es.										
7.	72 h n "ng Aedic	힐	(Specify only highest gra	ade completed)		(Give)	lent's Usual (kind of work (O NOT use re	done du	tion <i>iring m</i> ost	t of workin	ng	16b.	Kind of Business Ir	dustry	
712	vithin liene. or tha		Elementary/Seconday (0-12)	College (1-4	4 or 5+)	1	istere		ırse				Medical		
р	filed within 72 hours after death with the Maryland al Hygiene. J other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at		17. Father's Name (First, Middle, Last)							er's Name	(First, Middle,	_			
/lar	d be f Aenta Arked ric er	유	John Litwin							Soph	ie Rupa	ar			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once.		19a. Informant's Name/Relationship (7)	vpe, Print)		19b. Mailir	ng Address (S	Street a	nd Numbe	er or Rural	Route Numbe	er, City o	or Town, State, Zip	Code)	
Σ	nd 2 sealth m 27		William Grau	Son		139	14 Cas	stle	bar	Driv	e; Gler	nwoo	d, MD 21	738	
ore	e 1 ar	- 64	20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐	Removal from 9		Place of Dispo			,	D	ate	20c. l	Location - City or T	own, State	
Ë	. Pag iment tant: jury c	l	4 Donation 5 Other (Special			lantic	Crema	tor	y	6/8/			n Burnie		
3alt	Departition Depart		21. Signature of Funeral Service Licens		1/1	22	Name and a	Address	of Facility	y Ste	rling A	sht	on Schwa	b Witzk	ce
	⊕ □ = # 0	Н	Mel	LL/	10	3	.630 Ed	<u>imor</u>	<u>idson</u>	_Ave	nue; Ca	aton	sville,	MD 2122	28
C	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or compositive, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on eac	or as a consequ	úe	CANO	braying by S	my	cardiac or	tespiratory and	rest,		Approximate Interval Betwonset and D	ween
39.	be executed sician and burial-transit	I Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c	or as a consequence as a consequence)			Mat				gen	<u></u>
9	te be exe hysician he burial	dical		d											
. Box 687	Attending Physician: The law requires that the death certificate be executed ar death. sctor: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		irth 2 🗌 Feta ant at time of d	I death 3	Ectopic pre Other (spec	gnancy				1	23d. Date of delive	•	'ear
P.O.	ires that the dea	Y P	Part II. Other significant conditions co	-		-	, ,	use give	n in Part I		23e. Did to	obacco	use contribute to t	he cause of de	eath?
Ś	n sign	g pe	probable mita	nanc	LING	cance	V				1 🗆	Yes 2	No 3 □ Pro	bably 4 🗆 t	Jnknown
oro	v require s been si should I	Set	1		ð						24a, Was	an	24b. Were auto	psy findings a	vailable
ec	The law ate has page 2 s	E										rmed?	death?	impletion of ca	ause of
a F	sician; The certificate rector, pag	Be C	25. Was case referred to medical					26. Pla	ce of Deat	th (Check	1 \(Yes\)	2 🗶 N	No 1 ☐ Yes	2 🗀 No	
Vit	ysici lis cer direc	일	examiner? 1 Yes 2 No	Hospital:	npatient 2 🗆	ER/Outpatier	t 3 🗆 DOA	Other	: 4 □ Nu	ırsina Hon	ne 5 🗆 Besir	dence	6 Other (Specifi	10201	1,10
of	iding Physi th. After this c funeral dir		27. Manner of Death 1 2 Natural 5 Pending	28a. Date o		28b. Time of injury		. Injury work?	at		8d. Describe h		1	700-01	
on	ttendir death. :tor: Af	<u>ii</u>	2/ Accident Investigation		,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	М		′es 2 □	No					
Division of Vital Records,	p # # # E	al Certificate:	4 Homicide determined	28e. Place of building	of Injury - At ho g, etc. (Spec <i>ify)</i>)					City or Tou	vn, State			er,
	the Hospital hin 24 hours a the Funeral C	Medical	29a. Certifier (Check only one) 3 Certifying Physical Examination (Check only one) 3 Certifying Nurse	ner: On the basis	of examination	and/or invest	ioation, in my	oninior	death oc	curred at t	he time date a	and plac	e and due to the ca	upa(e) and mar	nner stated.
	To th Withii To th		29b. Signature and title of certifier						number				ate signed (Month,		
	ر (Herall	W5			10	5	830	2		Jul	Ne 5 2	010	
	5		30. Name and address of person who c	completed cause	of death (Item	23a) (Type, P	rint)	C	Mad	les	Sr To	2500	on m	0	
	Stat Registra	_	31. Date filed (Month, Day, Year)	32. Re	gistrár's Signa	ure	, , , ,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death GOODE M Physician/ Mg Day ARU Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death
Baltimore Examiner 4b. City, Town, or Location of Death Season's Hospice Randallstown Social Security Number 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2🗓 F 08/06/1959 219-80-8483 50 **Director** Yrs MDUsual Residence of Decedent 28a-f shov death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Baltimore Essex 1 🗌 Yes 2 🔀 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a 21221 USA 330 Stemmers Run Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinane. ģ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Completed 3 Widowed 4 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Service Be 18. Mother's Name (First, Middle, Maiden Sumame)

Mary Elizabeth Oakman 17. Father's Name (First, Middle, Last) ٥ Franice Louis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory S. Gress / Nephew 330 Stemmers Run Road, Baltimore, MD 21221 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 SCremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Journey Crem. 6/7/2010 Final Woodbine, MD rvice Lice see Dorota 22. Name and Address of Escilla Cremation Services 21. Signature o Marshall laskall PO Box 1413, Baltimore, MD 21203 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 X No
9 ☐ Unknown Pregnant at time of death Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably ► Unknown should ! peen s 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 s autopsy perform death? certificate 2 🗆 No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? in 24 hours after deatn. he Funeral Director: After this of holeted filled in by the funeral dire 1 Yes No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

State Registrar 31. Date filed (Mo.

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year MORTON LOUIS GREEN 0515M 100 2010 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4c. County of Death City, Town, or Location of Death 05 Baltings 1+1more N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 8. Date of Birth **Funeral** Months Hours Min 047774937 216-34-1126 73 MD Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? Funeral items 23a 35 STONEHENGE CIRCLE, #9 21208 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 7 Black, White, etc. 1 Never Married 2 X Married ŏ þ Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. If Yes, Give Year or Dates WHITE "natural", Specify: 3 Widowed 4 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working ith and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) INSURANCE ADJUSTER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ **JOSEPH** GREEN RACHAEL **BROWN** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heath ar Important: If item 27 is any injury or other trau 35 STONEHENGE CIRCLE, #9, BALTIMORE, MD KAY GREEN/WIFE Baltimore, 20a. Method of Disposition 20b. PARIOTINGTON CHI ZUK 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State AMUNO CEMETERY 06/06/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens e 22. Name and Address of Facility SOL LEVINSON & BROS., INC 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Morten Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner 71600H if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) and -transit Physician: The law requires that the death certificate be executed evd that initiated events e to (or as a consequence of resulting in death) Last burial-1 physician the burial Physician/Medical 22 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Tes 😾 No 3 🗌 Probably 4 🗀 Unknown 24b. Were autopsy findings available 24a. Was an Jas autonsy prior to completion of cause of death? After this certificate has funeral director, page **≫** No Yes 1 Yes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number MD. D38570 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey £. MD. Suite 300 7501 OSIET Dr Towson MD 21204 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#16b,19b,perFH,G904,6/8/2010,WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6:18 р м Physician/ Margie Joyce Temple Gabriel Junie 2010ar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** Examiner 4c. County of Death 524 N. Charles St. Apt. 1212 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Servotth, Day 2 earl 938 7. Age (In yrs. last birthday) Social Security Number 9. Birthplace (State or Foreign Countrinaryland **Funeral** 1 M 2 XF 218-42-1004 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland traumatic event, the Me Jical Examiner must be notified at Director Maryland Baltimore 1 Yes 2 □ No 10f. Zip Code 0 10e. Street and Number 10g. Citizen of What Country? 23a Funeral 21201 U.S.A. 524 N. Charles St. Apt. 1212 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Me.ical Examiner muones. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) AT&T Elementary/Seconday (0-12) College (1-4 or 5+) Traffic Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Garfield Stewart Cora Temple Johnson 19b. Mailing **Times weep**d Numbe **Columbat**, Md. 21045 19a. Informant's Name/Relationship (Type, Print) Ernest Gabriel, Jr. - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Faiths Crematory June 8,2010 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Manchester, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. le-A 11605 Reisterstown Rd. Owings Mills, MD. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition MYUCARAIAU INFAKUTION Physician/ ACUTO Acnto Medical resulting in death) Due to (or as a consequence of) Examiner ASUVA 10 X KJ Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events.) Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Month Day Year 9 Unknown Division of Vital Records, P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 🏋 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 No Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: |은 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ٥ 06/07/2010 110246 mp 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 DRIVE 2111) Chusshudds Courtel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 20¶0 Theodore A. Heun 8:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 2500 Kensington Gardens #405 Ellicott City Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland Months March 19 1 🕅 M 2 🗆 F Hours Yrs 217-40-7757 69 Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County filed within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Ellicott City 1 Yes 2 No Howard <u>Maryland</u> 10e. Street and Numbe 10f. Zip Code 10q. Citizen of What Country? Funeral 21043 USA 2500 Kensington Gardens #405 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Public School System 5+ Teacher of Health and Mental Hygie if item 27 is marked other ir other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be fill iment of Health and Mental tant: If item 27 is marked o ည Margaret Neujakat August Heun 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2500 Kensington Gardens #405 Ellicott City, MD 21043 Judith L.N. Heun, Wife 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 6 Department of Important: If any injury or once. Metro Crematory Inc.: 06/07/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor ²² Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus Onset and Death Immediate Cause (Final HAYOTHOPHIC LATERAL SCLEROSIS Pnysician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No a Unknown sate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 5 Pending injury work?
1 ☐ Yes 2 ☐ No ☐ Accident Investigation after death the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nu se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature a 29d Date signed (Month, Day, Year,

Registrar

DHMH 17 Rev 7/2009

State

4801 Dorsey Hall Drive Suite 201 Ellicott City, MD 21042

dress of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ ${\tt Mav}^{\tt Month}$ 30, Day 2010 Frances E. Harmon 4:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death North Arundel Nursing & Rehab. Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😾 F 0avs Hours Min 0872871924 Director 189-16-2784 85 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Merical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Yes 2 X No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 313 Hospital Drive 21061 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black White etc. ģ 1 Never Married 2 Married 1 Xes 2 No
If Yes, Give WWII Era
Year or Dates. Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10 College (1-4 or 5+) Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francis M. Wray Katie E. VanSciver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Burkhard, Daughter 808 Teakwood Drive, SEverna Park, MD 21146 permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other t other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 XCremation 3 Removal from State Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 06/04/2010 Glen Burnie, MD 22. Name and Address of Facility Auer Cremation Services 4100 Jonestown Road, Harrisburg, PA 17109 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Medical resulting in death) as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE f yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Other significanty conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 performed? Yes 2 N 2 × No 1 Yes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 🔲 Yes 2 🔀 No ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 🗌 No Accident Investigation 24 hours after deatle Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the only one) 29b. Signature and title of ce 29c. License number 29d. Date signed (Month, Day, Year,

Registrar

Burnie

gause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

Craw

person who completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 6 Physician/ 2010 7:30 ам Nettie Haves Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NA Baltimore Blue Point Nursing Home If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Director 226-28-557 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If them 27 is marked other than "natural", or items on any injury or other trainment. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA Belvedere Ave. 21215 2525 W. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No 1 Yes 2 No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Black Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Domestic 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jennie Alexander Eddie Haves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OH 44720 Bletchlev N.W. Canton. <u>Jane H. Dancy</u> Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/12/2010 Clarksville. ukes Bap.Cem! 21. Signature of Funeral Servi 22. Name and Address of Facility Wylie Funeral Home, P.A. Gilmor Street Baltimore MD 23a. Part 1. Enter the disease, or condications that caused the death. Do not enter the mode of rying, such as circliac or respiratory arrest, shock, or heart failure. List only one cause in the line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 Li Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed' 2 No 1 Yes funeral director, 25. Was case referred to medica æ 26. Place of Death (Check only one) Other: ၉ 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Mannet of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work 1 Tyes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DUITE 203 W 2835 SHITH AVES 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2038 Patty Lou Hartson May 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hospital Baltimore Saint Agnes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth

(Month, Day Year)

11-27-1928 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🕱 F Months Days Hours Min. Country)
Illinois 482-26-4094 81 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Erasi Instrument on Holling an Director 1 ☐ Yes 2 X No Maryland 1 4 1 Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with n and Mental Hygiene. Is marked other than "natural", or items 23a or 3010 North Ridge Road C610 21043 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖔 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 2 Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Commercial Credit Analyist Bank of America 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Sylvester Olive Ann Moore ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any injury or other traun once. Robert J. Hartson (Son) 13160 Brighton Dam Road Clarksville, Maryland 21029 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 06-02-2010 Atlantic Crematory 4 Donation 5 Dother (Specify) Glen Burnie, Maryland 22. Name and Address of Facility
Witzke Funeral Homes, Inc. 21. Signature of Fluneral Service Licenses Whili Columbia, Maryland 21045 <u>5555 Twin Knolls Road</u> 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Intra-abdominal 72 hours disease or condition resulting in death) Seps.s /Medical Due to (or as a consequence of): Examiner leakage from gastrostomy tube 72 hours if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of). tending physician a r use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☒ No Month Year Day 5 Other (specify) the detached 9 Unknown signed by till be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No Completed 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b irector, page 2 sh 24a. Was an autopsy 2 X No 1 □Yes 2 X No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After t completely filled in by the funera 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated.

Box 68760.

P.O.

Division of Vital Records,

Hartson, Patty

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

001209104

32. Registrar's Signature

900 S. Caton

AS24385284106

Avenue

29d. Date signed (Month, Day, Year)

Baltimore MD

State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Physician 10:55 A^M 2010 Richard Preston Hawes June /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 713 Maiden Choice Lane Apt 2301 Catonsville Baltimore oreign nd Limits

Funeral Director

filed within 72 hours after death with the Maryland Be Completed by Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mydical Evant in counts be notified at once.

ျှ

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director,

5. Social Security N			ge (<i>in yrs. i</i> as	st birtnaay)	Mantha Dava	Hours	Min. 8. Date of (Month,	Day, Yea	(7)	Country)
219-10-0	906	1 🖾 M 2 🗆 F	84	Yrs.	Months Days	nours	Nov.	28, 1	925	Rhode Island
Usual Residence of	f Decedent									
10a. State	10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limit
MD	Baltimo:	re	Cat	tonsvi	.11e					1 □ Yes 2 🔯 N
10e. Street and Nui	mber				10f. Zip Code			10g. (Citizen of Wh	nat Country?
713 Maid	len Choic	e Lane Apt	2301			21228			USA	
11. Marital Status		12. Was Decedent Armed Forces	Ever in U.S.	13. V	Vas Decedent of	Hispanic O	rigin? (Specify Yes or an, Puerto Rican, etc.)	No-		- American Indian,
1 ☐ Never Marr	ried 2 Married	1 X Yes 2 □								White, etc.
3 🔀 Widowed	4 Divorced	If Yes, Give Year or Dates:		1	□Yes 2XNo	Specify	r.		Specify:	White
(Spec	15. Decedent's E	ducation ade completed)		(Give k	ent's Usual Occu	durina mos	st of working	16b.	Kind of Bus	iness/Industry
Elementary/Seco	ondary (0-12)	College (1-4or	5+)	life. D	OO NOT use retire	ed)				
		4		Sale	s Rep			S	teel	
17. Father's Name	(First, Middle, Last	')				18. Moth	ner's Name (First, Mide	dle, Maid	en Surname)
Russell C	. Hawes					Amey	y M. Peck			
19a. Informant's N	lame/Relationship	(Type. Print)		19b. Mailing	g Address (Stree	t and Numb	ber or Rural Route Nu	mber, Cit	or Town, S	itate, Zip Code)
Robert Ha	ıwes	Son		8289	Glenmar	Road	; Ellicott			yland 21043
20a. Method of Dis	position		20b. Pla	ce of Dispos	sition (Name of natory or other pla	ice)	Date	20c.	Location - C	City or Town, State
	☐ Cremation 3 ☐ 5 ☐ Other (Special	Removal from State fy)		st Law	m Mem.G	arden	6/10/2010			sville, MD
21. Signature of Fu	uneral Service Lice	nsee		22.	Name and Addr	ess of Facil	ity Sterling	Ash	ton Sc	hwab Witzke
m	ck to	Mme	mold.	50 Fu 16	neral Ho	ome of odson	f Catonsvi Avenue: C	lle, atons	Inc. sville	MD 21228
23a. Part 1. Enter t shock, or hea	disease, or com art failure. List only	plications that cause one cause on each l	d the death.				s cardiac or respirator			Approximate Interval Between
Immediate Cause disease or condition	(Final	190	1111							Onset and Death
resulting in death)		a. Due to (or as	s a conseque	ence off:						years
		Due to (or a	a conseque	1100 017.						9
Sequentially list co	onditions,	b								
Sequentially list co if any, leading to im cause. Enter Unde	nmediate erlying	Due to (or as	s a conseque	nce of):						
Cause (Disease or that initiated events	REIGIA	C								
resulting in death)	Last		s a conseque	nce of):						
		d .								
IE EEMALE.										
IF FEMALE: 23b. Was deceden	nt pregnant	23c. If yes, outcome							23d. Date	of delivery
in the past 12	? months?	1 ☐ Live birth 4 ☐ Pregnant			Ectopic pregnan Other (specify)	су			Mont	th Day Year
1 Yes 2		9 Unknown			(5000.7)			_		

Completed by Physician/Medical Examine 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

Maiden Choice In Catonsville MD

State Registrar

20+1

Physicia /Medica Examine

	For State	State of Maryla		artment of He				1 0	, 00	
	Registrar 1. Decedent's Name (First, Middle, Last)			Tillicate of D		2. Date of Deat	eg. No.		3. Time of Death	_
1	1. Decedent's Name (First, Wildlie, East)	John J. H	arvath,	Jr.		JUNE	Day	Year	10:10 A M	
r	4a. Facility Name (If not institution, give s		0	4b. City, Town, or L		4 -	4c. County			_
	SINAI HOS	to latiq	BAltimo	re BA	Itimore	City	N/A			
	5. Social Security Number 6. Sex 219–32–5397	7. Age (In y. 74	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 2	Year)	Coui	place (State or Foreign ntry))
	Usual Residence of Decedent									
	10a. State 10b. County	10c.	City, Town or Lo					1	0d. Inside City Limits	
25	MD N/A		Baltin	nore					types 2 □ No	
9	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cour	ntry?	_
2	2095 Rockrose Aven	ue		21:	211		U.	S.A.		
1	11. Marital Status	2. Was Decedent Ever in	U.S. 13.	Was Decedent of Hisp	panic Origin? (Sp	pecify Yes or No-			can Indian,	_
2	XXNever Married 2 ☐ Married	Armed Forces? 1 □Yes ♣₩No If Yes, Give		If Yes, specify Cuban,		Hican, etc.)		ck, White,		
5	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 □Yes 2 XX	Specify:		Specif	Whi	.te	
bleted	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece	dent's Usual Occupati	ion	rina	16b. Kind of B	usiness/In	dustry	
<u></u>	Elementary/Secondary (0-12)	College (1-4or 5+)		kind of work done dui DO NOT use retired)	rilly most of work	ung .			_	
5	6th		Exte	erminator			Pest	Contr	ol	
n n	17. Father's Name (First, Middle, Last)			1	8. Mother's Nam	e (First, Middle, I	Maiden Surnan	ne)		
5	John James Harva	th			Pearl	Emma Rho	odes			
	19a. Informant's Name/Relationship (Typ	ne. Print)	19b. Mailir	ng Address (Street an	d Number or Ru	ral Route Number	r, City or Town,	, State, Zip	Code)	
	James Wolf (Nephew)	2 Cas	stell Sourt	t Nott	ingham,	MD 21	236		
	20a. Method of Disposition	20t	. Place of Dispo	sition (Name of natory or other place)		Date	20c. Location -	- City or To	own, State	
	1 ☐ Burial 2 ☐ Premation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		Crematory	;	/10	Glen B	urnie	. MD	
Ì	21. Signature of Funeral Service License		22	2. Name and Address	of Facility				.,	_
1	Market (er	mel	36	rgee-Henss 31 Falls F	s-Seitz Road Ba	tuneral	Home,	Inc.		
	23a. Part1. Enter the disease or compli- shock, or heart failure. List only one	ns that caused the de							Approximate Interval Between	
	Immediate Cause (Final	ACDIR	Tion	, Prie	mon	i A		d.	Onset and Death	
	disease or condition resulting in death)	Due to (or as a cons	equence of):	(11.2.					VI CO 00 10	-
2	Sequentially list conditions, and leading to the date cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence offic							_
	Cause (Disease or injury that initiated events									
Š	resulting in death) Last	Due to (or as a cons	equence of):							
2	d.									
	IF FEMALE:									
	23b. Was decedent pregnant 23	Bc. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fe		☐ Ectopic pregnancy				ate of delive	•	
2	in the past 12 months? 1 □Yes 2 □No	4 ☐ Pregnant at time of		Other (specify)			Mo	onth	Day Year	
	9 Unknown					1				7
5	Part II, Other significant conditions cont	tributing to death but not r	Di	N .	in Part 1. SeasE				he cause of death?	
3	Chronic OBSI	200,100	TUTMON	imicy DI	2-470	1 Ye	es 2 No	3 ☐ Prot	bably 4 Nonknown	
2						24a. Was a autops		Were auto	opsy findings available impletion of cause of	
5						perforr 1 □Yes		death? 1 □ Yes	2 □ No	
	25. Was case referred to medical examiner?				26. Place of Deat	th (Check only on	e)			_
2	1 ☐ Yes 2 ☐ No	ospital: 1 ☐ Inpatient 2	ER/Outpatier	nt 3 ☐ DOA Other:	4 Nursing Ho	ome 5 🗆 Reside	ence 6 □Oth	ner <i>(Specii</i>	fy)	
:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	f 28c. Injury a Work?	at	28d. Describe ho	ow injury occur	red		
5	2 Accident investigation			M 1 □Ye	s 2 No					
	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, streecify)	eet, factory, office		28f. Location (St City or Town	treet and Numb n, State)	ber or Rura	al Route Number,	
3	00-0-16-	I .			1					_
2	29a. Certifier (Check only one) 1 CertifyIng Phys 2 Medical Examin	ician: To the best of my ker: On the basis of examinand manner stated.	knowledge, deatl ination and/or in	h occurred at the time vestigation, in my opir	e, date and place nion, death occur	, and due to the c rred at the time, d	ause(s) and mate and place,	anner as s and due to	stated. o the cause(s)	
I	29b. Signature and title of certifier			29c. License r	number	2	9d. Date signe	ed (Month,	Day, Year)	_
	I most open	40		Doc	5455	-6 -	TUALE	6.	2010	
-	30. Name and address of person who con	npleted cause of death (I	tem 23a) (Type,	Print)			1000			_
	FREDERICK J		IR MC) SINA	off It	spital	of	BAL	timore	
	31. Date filed (Month, Day, Year)	32. Pagistrer's Sig	The second second							
	JUN 0 8 201	U Sensur	1. 4	arkel						_
1										

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15:08 ZOID Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner 4c. County of Death N/A 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral OCTh. Day Year 933 Months Min N^{Coun}CAROLINA 1 **⅓**M 2 □ F 245-50-9936 76 Yrs Director Usual Residence of Decedent 28a-f shor 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 ☐ Yes 2 🛚 No ANNE ARUNDEL PASADENA MD 10e. Street and Numbe 10f. Zin Code 10g. Citizen of What Country? items 23a or Funeral 1568 FAIRVIEW BEACH ROAD 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 9 þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed WHITE event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event "t (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) VEHICLE TRANSPORTER AUTOMOTIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ MARTIN LUTHER DOLA LOCKLEAR HUNT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA JEAN HUNT/ 1568 FAIRVIEW BEACH ROAD, PASADENA, MD 21122 WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) GLEN HAVEN CEMETERY 6/9/10 GLEN BURNIE, MARYLAND 21. Signature of E Name and Address of Facility
TLLY & ZEILER
901 EASTERN A **Ť** 9 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on early line. pet and beath Immediate Cause (Final Diverticali-Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or se a consequence or) attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Cectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 L 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 0 3 Probably 4 Unknown Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy perform death? 2 000 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 1 🗌 Yes 2 🗌 No To the Funeral Director: A completed filled in by the 1 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

nd address of person who completed ca

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 09:08 AM rsie Howar 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14:0 256 If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits **Funeral Director** 1 Yes 2 □ No 10f. Zip Code 12 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status Race - American Indian Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates. Black, White Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2. No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nost of working conday (0-12) College (1-4 or 5+) Be athers Name (First, Middle, Last) 2 Name/Relationship (1) Print) Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sign store of Funeral Service Line 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death hemorrh Physician disease or condition Medical resulting in death) Due to (or as a consequent **Examiner** 6 Sequentially list conditions, if any conditions in mortal cause. Enter Underlying Cause (Disease or linjury that initiated events and the conditions of the Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Dav Year 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 2000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

10-03952 George Isabell

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 17805 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Month Day May 24, 2010 0610 hrs **Medical Examiner** George Isabell 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5, Social Security Number 117 k 6. Sex 7, Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Months Days Hours Director Country) 2___F 1 📉 M 58 Yrs Sept 28, 1951 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show 1 Yes 2 No s 23a or 28a-f shove notified at once. permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho Washington Hagerstown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18701 Roxbury Road 21746 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status
1 Never Married 2 Race - American Indian, Black. , or items Armed Forces?unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Married Yes 4 Divorced Specify: black 3 Widowed If Yes, Give Year Yes 2 No specify: δ 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed unl during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) or other traumatic event, the Medical unk unk 17. Father's Name (First, Middle, Last) unk 18.Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E Penn Street: Baltimore Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility "S. State Anatomy Board; 655 W. Baltimore Street Ronald Wade, Director 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. Between Onset and /Medical a. Hemoperitoneum Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Ruptured Metastatic Hepatocellular Carcinoma Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed attending physician and or use as the burial - tran Physician/Medical UNPENDED AMENDED Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Fetal death Day 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ó ξ 1 Yes 2 No 3 Probably 4 ✔ Unknown Diabetes Mellitus Completed Records, 24a, Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 ER/Outpatient 3 DOA this 1 Yes After 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 V Natural Pending 1 Yes 2 No Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) (Specify) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) OCME May 24, 2010 30 Marme and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006**

State

Registrar

OCME

31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 3, 2010 Andrew Raymond Illig 5:50 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 30 Eldwick Court Montgomery Potomac If Under 1 Year 8. Date of Birth (Month Day, 7. Age (In vrs. last birthday) If Under 24 Hrs. **Funeral** Sex 1 X M 2 □ F 9. Birthplace (State or Foreign Days Director 214-49-3802 13 T996 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event the Marken. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Montgomery Potomac 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 30 Eldwick Court 20854 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black. White, etc. Completed by 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced White Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Student Private School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Douglas J. Illig Jeannine Gocayne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas J. Illig/Father 30 Eldwick Court, Potomac, Maryland Date 7, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) June St. Mary's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Rockville, Maryland 21. Signature of Funeral Service License Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 Willian U. ₩01173 tur 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Inset and Death Nonths Physician Osteosarcoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 13 Years Neuroblastoma Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year cate has been signed by the page 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death.

ever after death.

filled in by the funeral director, page 2. performed?
☐ Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 🛛 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending X Natural 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certifier

Nita Seibel, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

111 Michigan Avenue, NW, Washington, D.C.

D36249

29d. Date signed (Month. Day, Year)

June 3, 2010

20010

			Please To Amend 20b-c, per	ype or Print in Black Indelible Ink. Ensure Fh g904 6/25/10 TT State of Maryland / Department of Health and	All Copies A	re Legible.
		_	For State Registrar	Certificate of Death	Reg.	2010 7007
	Physicia		1. Decedent's Name (First, Middle, Last)	2502	2. Date of Death Month	Day Year 3. Time of Death
1	Medic Examin		4a. Facility Name (if not institution, give stre	pet and number) 4b. City, Town, or Location of Dea		4c. County of Death
n month	Funeral		5. Social Security Number 6. Sex	Medical Center	s. 8. Date of Birth	9. Birtholace (State or Foreign
	Director s		216 - 36 - 1594 VSual Residence of Decedent	M 2 □ F 69 Yrs. Months Days Hours Mir	8. Date of Birth Month, Day, Yea	1941 Maryland
	aryland a-f sho fied at	Director	10a. State 10b. County	rundel Odenton		10d. Inside City Limits 1 Yes 2 □ No
	th the M 3a or 28 t be not	al Dir	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
	leath wit tems 2: er must	Funeral	522 Domain 11. Marital Status	Court 2 1113 2 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (if Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married . 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Specify Cuban, Mexican, Pue 1 Yes, Specify: 1 Yes 2 No Specify: Year or Dates.	по нісап, етс.)	Black, White, etc. Specify: Plack
21215-0036	72 hour n "natul 1edical	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a. Decedent's Usual Occupation completed) (Give kind of work done during most of w.	orking 16b	. Kind of Business Industry
212	d within ygiene. her thai it, the N		Elementary/Seconday (0-12)	College (1-4 or 5+) Sea food Manage	ger	Giant Foods
Maryland	l be filed lental H rked ot tic even	To Be	17. Father's Name (First, Middle, Last) Toseph E 3	Tohnson 18. Mother's N	me (First, Middle, Maid ra, Hud	en Surname) AheS
Mary	2 should th and M 7 is ma traumat		19a. Informant's Name/Relationship (Type,	Print) 19b. Mailing Address (Street and Number or F	Rural Route Number, City	or Town, State, Zip Code)
	of Healt of Healt fitem 2 rother		20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Re	20b. Place of Disposition (Name of	Date 200	DOM MU 21113 Location - City or Town, State Lansdowne
Baltimore,	permit. Page 1 Department of Important: If i any injury or o		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Greenmount 6-	14-2010 18	altimore, MD
Ba	permit Depar Impor any in		Vaughw C.	Liene 22 Name and Address of Facility Youngh C. Green 5151 Baltymore	National	PILE (ZIZZA)
١,	nysician/	3 1	23a. Part 1. Enter to disease, or complications shock, or heart failure. List only one of Immediate Cause (Final	ations that caused the death. Do not enter the mode of dying, such as cardia cause on , ch line.	ac or respiratory arrest,	Approximate Interval Between Onset and Death
	Medical Examiner		disease or condition resulting in death)	Du to (or as a o'nsequence of):		years
		iner	Sequentially list conditions, if any, leading to immediate couse Enter Underlying	Due to (or as a consequence of):		
	executed an and rial-transit	Examiner	Cause (Disease or linjury that initiated events c. resulting in death) Last	Due to (or as a consequence of):		
		dical	d.			
(68760	eath certificate be attending physici for use as the bu	an/Me	200. Was decedent pregnant	c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery
. Box	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Extended Deactor: After this certificate has been signed by the attending physicil thed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medic	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 5 Other (specify)		Month Day Year
, P.O.	ss that the dea igned by the a be detached f		Part II. Other significant conditions contr	ibuting to death but not resulting in the underlying cause given in Part I.		to use contribute to the cause of death?
Records,	v requires tr been signe should be	Completed by	mayer	Marie Marie	1 ☐ Yes 24a. Was an	2 No 3 Probably 4 Inknown 24b. Were autopsy findings available
Rec	sician: The law certificate has rector, page 2 a				autopsy performed	prior to completion of cause of death? 1 □ Yes 2 □ No
of Vital	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 Hos	spital: 2 ER/Outpatient 3 DOA Other:	eck only one) Home 5 Residence	6 ☐ Other (Specify)
n of	ding Ph h. After thi funeral		27. Manner of Death 1 Avatural 5 Pending	28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? M 1 Yes 2 No	28d. Describe how in	
Division	r Atten ter deat irector: 1 by the	Certificate:	2 🖸 Accident Investigation 3 🗍 Suicide 6 🗎 Could not be 4 🗍 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
۵	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical C	29a. Certifier 1 Pertifying Physici	an: To the best of my knowledge, death occured at the time, date and place,	and due to the cause(s	and manner as stated.
	the Ho ithin 24 orthe Fu	Mec	(Check 2(∟ Medical Examiner	Ton the basis of examination and/or investigation, in my opinion, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge, death occurred at the time, date and provided in the best of my knowledge.	d at the time, date and pla place, and due to the cau	ace, and due to the cause(s) and manner stated. se(s) and manner as stated.
	F 3 F 8		Susan HK	highrun Diff 3	290.	Date signed (Month), Day, Year)
			30. Name and address of person wild com	pleted cause of death (Item 23a); (Type, Print) Ofense H	ery Ans	1000ly MB 21401
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1	

OP.

DHMH 17 Rev 7/2009

ORIGINAL

M

Year

2 No

29d. Date signed (Month, Day, Year)

May 28, 2010

Hospital or Attending Physician: Director: within 24 hours after To the Funeral Direc

> State Registrar

Nedi

beside roadway

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

determined

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Donna M. Vincenti, MD

(Specify)

and manner stated

Assistant Medical Examiner

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 12:38рм Franklin F. Kuyawa 2010 June /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Heritage Nursing Center Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 17,1923 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Min. Months 1 XM 2 ☐ F Hours 212-20-7143 86 **Director** MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Examprer must be notified at 1 □Yes 2 No Director MD Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 183 Bennett Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify. þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, in a Monee. Elementary/Secondary (0-12) College (1-4or 5+) PArts Manager Bob Bell Chev.Co. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Kuyawa Anna Fehn မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bernadette Vetter /daughter 6403 Danville Ave. Baltimore MD 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State SacredHeartofJesus 6/10/2010 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service Licensee 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 arres Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and -tran Due to (or as a consequence of): burial-Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) signed by the a 1 □Yes 2 No 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 🔲 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 16 certificate 25. Was case referred to nedi examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To funeral c 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed P.O. Box 68760, Records, Division of Vital Physician: this Hospital or Attending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fi To the I within 2 To the

filed within 72 hours after death with the Marylanc

Maryland 21215-0036

Baltimore,

30. Na erson who complet 31. Date filed (Month, JUN 08

and manner stated.

State Registrar 29a, Certifier (Check only one)

29b. Signature and ti

1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 20**°**0 Elizabeth Smith Lottich 11:20P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Augsburg Lutheran Home Baltimore Gwynn Oak Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** June 25, 1921 1 □ M 2 🔽 F Months Days Hours New York 214-46-1505 88 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Baltimore N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 600 Light Street, Apt. 735 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? 1 ☐ Yes 2 🗓 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🎇 No Specify: If Yes, Give 3 XWidowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Morris Smith Lillian Susan Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2608 Rittenhouse Avenue Baltimore, Maryland 21230 <u>Jonathan Lottich,</u> Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 06/07/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ntercerebra Physician. disease or condition resulting in death) NOUS Medical Due to (or as a consequence of) Examiner elescherot Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) ed by the a g ☐ Unknown g Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate I Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 5 Pending work? 1 Natural Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 37573 2010 June 30. Name and address of person who completed ca use of death (Item 23a) (Type, Print battone MD MD Jef **7831** 2/209 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06/2010 Russell Langosch Kenneth 10:30 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Potomac Valley Nursing Home Montgomery Rockville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min 11/10/1926 Tilinois 83 Director 350-18-5600 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Chevy Chase MDMontgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20815 United States 3402 West Coquelin Terr. hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Was Decedent Ever III J.O. Armed Forces?

1 M Yes 2 No If Yes, Give 1947 1949
Year or Dates. 1951-1952 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ other Musician Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Grover Langosch Marjorie Stein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul R. La<u>ngosch - Son</u> 3402 West Coquelin Terr. Chevy Chase MD 20815 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State 6/8/2010 Chesapeake Crematory Beltsville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Servi mois39 933 Gist Ave 20910 22. Name and Address of Facility Rapp Funeral & Cremation Ser. Silver Spring MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Chronic Obstructive Lung Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami ig physician and as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 🖎 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? has performe certificate 2 🗌 No Yes 2 No 1 Yes or Attending Physician: after death. 25. Was case referred to medical **Division of Vital** director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) hours after death. neral Director: After this I filled in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 🗌 No Accident 1 🗌 Yes Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital chin 24 hours at the Funeral D Medical 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier To the H within 24 To the F 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) ~ D38262 06/07/2010 10x1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 Research Blvd Rockville MD 20850 Dr. Anurita Me 31. Date filed (Month, Day, Year) Mendhiratta 32. Registrar's Signatur State

DHMH 17 Rev 7/2009

Registrar

JUN 0 8 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Vivian May Lynch 06:35 A M 06 2010 02 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Sunrise Assisted Living Pikesville Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Months Hours 1 M 2 XF Days Yrs 90 220-36-9270 Director 05/30/1920 MD Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show It e Medical Examiner must be notified at Director 1 ☐ Yes 2 TN No MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Old Court Road Funeral 3800 21208 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 図 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 21 No Specify: ₫ Specify. 3 ☐ Widowed 4 K Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 721 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene." Important: if item 27 is marked other than "any Injury or other traumatic event, it e Magnes." College (1-4or 5+) Elementary/Secondary (0-12) 5+ School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ John A. Higdon Susanna Lee 19a. Informant's Name/Relationship (Type. Print) 21133 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt. 203 Mr. Lawrence A. Lynch / son 3924 Noyes Circle Randallstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 6/07/2010 Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. 101357 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans Box 68760 physician Physician/Medical the attending p IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ■ No signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ icate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate 1 □Yes 2 Win Division of Vital 2 No 1 Tyes this certifical 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 de Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier License numbe 29d Date signed (Month, Day, Year)

5

State Registrar Name and address of person who completed cau

Date filed (Month, Day,

of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	,	Cen	tificate o	of Death		R	Reg. No.			
Physici		1. Decedent's Name (First, Mide	ile,Last)					2. Date of Dea Month	Dav	Year	3. Time of Death	
Medical Exam	ner	De Andre 4a. Facility Name (if not instituti	on aive street and av	Antion	nio		eper or Location of De	June 1, 2		- County of Do	0112 hrs	
		University Hospital	on, give street and nu	inber)		Baltimore	or Location of De	auı	4c. County of Death N/A			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Ye	ear If Under 24h	rs. 8. Date of Bi	rth(MM		Birthplace (State or	
Director		214 02 2570	1X M 2 F		27 Yr	Months Da		11/12	•	For	reign Country) MD	
		214-02-3570 Usual Residence of Decedent	142 2		21 "	<u> </u>		111/12	2/1	902	TID	
any		10a. State 10b. County		10c. City, 7	Town or Loca	ition					10d. Inside City Limits	
Aaryland 28a-f show 1 at once,	ō	MD	N/A		Ва	ltimor	е				1 X Yes 2 No	
Maryl 28a-1	Director	10e. Street and Number				10f. Zip Code			10g. Cit	izen of Wha t C	ountry?	
th the Maryland 23a or 28a-f sho notified at once			klin Str	eet		212	23		U	.S.A.		
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-fahent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 X Never Married 2 N		edent Ever in U.S rces?			lispanic Origin? (an, Mexican, Pue	Specify Yes or No rto Rican, etc.)	D-	14. Race - An White, etc	nerican Indian, Black,	
er dea , or it	Ē		1 Yes	2 🔀 No		Yes 2X	o specify:			Sansifu Di	a ak	
ırs aft t ural "	ρ	15. Decedent's Education (Spe	or Dates:		16a. Decede		ation (Give kind o	of work done	16b.	Specify: B		
5-0036 led within 72 hours a Hygiene. other than "natura ithe Medical Examir	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)	during n	nost of working li	fe. DO NOT use r	etired)			,	
036 rithin ene. rr than	ם	10th Grade			Tru	ck Hel	per		t	ruckir	ng co.	
5-0 iled w Hygid I othe		17. Father's Name (First, Middle						me (First, Middle,	Maiden			
21215-003 unld be filed withi Mental Hygiene, marked other tt	Be	Guy 19a. Informant's Name/Relation		per	1405 M-10	. Add		enda or Rural Route Nur		Bal		
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than numatic event, the Medica	ပို	Falisha Grif		er)				je DR.		•		
2 2 2 2		20a. Method of Disposition		20b. Pl	lace of Dispo	sition (Name of c		Date			or Town, State	
nore ages 1 nt of 1 nt: If other		1 X Burial 2 Crematio		iii State j	ematory or o		om 06	5/08/10	 D = 1	ltimo	an MD	
Baltimore, permit. Pages I as Department of Hee Important: If ite		4 Donation 5 Other S 21. Signature of Funeral Service		1 1		Hill C						
Dep Den ini	l	1 Dishel	hN.U	hellear	2	946PN.	Full tor	n Ave:,	Bai	fimor	10MB 21217	
Physician		23a. Part I. Enter the disease, of failure. List only one cause		used the death. I	Do not enter	the mode of dying	g, such as cardiad	or respiratory arr	est, sho	ock, or heart	Approximate Interval Between Onset and	
/M dical Examiner		Immediate Cause (Final disease	NA . 165 1 C	nshot Wound	ds						Death	
-		or condition resulting in death)	Due to (or as a	consequence of)	:							
	필	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of)	:						1	
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	C	consequence of)								
ited d ansit	Ä	events resulting in death) Last	d.	consequence or)								
760, icate be executed thysician and the burial - transit	Medical	UNPENDED		per ME (COO/ 6	/10/10 7						
760, icate be physicite the burither bu	Š	IF FEMALE:	23C. II yes, C	utcome of pregna	ancy	/10/10	. 1		230	d. Date of deliv	ery	
OX 687 ath certific	/sician/	23b. Was decedent pregnant in t past 12 months?		rth ant at time of dea	th - =		Ectopic preg	nancy		Month	Day Year	
Box 68 e death certif the attending ed for use as	Sic	1 Yes 2 No 9 Un	known 9 Unkno		tn 5 O	ther (Specify)						
~ # > g	Phy	Part II. Other significant condi	tions contributing to	death but not res	sulting in the	underlying cause	given in Part I.	23e. Did to	obacco	use contribute	to the cause of death?	
ords, P.O w requires that t s been signed by	d b							1 Yes	s 2 🗸	No 3 P	robably 4 Unknown	
rds requi	Completed							24a. Was autop			autopsy findings available o completion of cause of	
Recol The law icate has	틹								rmed?	death	?	
	ပို	25. Was case referred to medical	al			26.Plac	e of Death (Chec		2		163 2 10	
of Vital Records, ng Physician: The law require After this certificate has been si nneral director, page 2 should b	0 8	examiner? 1 ✓ Yes 2 No	Hospital: 1 Ir	npatient 2 🗸 E	ER/Outpatien	t 3 DOA	Other Nurs	sing Home 5	Reside	ence 6 Otl	ner:	
on of Vital Fending Physician: ath. pr: After this certifithe funeral director.	<u> </u>	27. Manner of Death	28a. Date ((Month,	of Injury Day Year)	28b. Time of		ury at Work?	28d. Describe Subject sho		ury occurred		
sion trend death. ctor:	atio	Pen	ding stigation 6/1/2	010	0043 hrs		Yes 2 V No					
Division pital or Attendion ours after death. teral Director: Affilled in by the fi	Certification:	dots	ld not be	of Injury - At hor	ne, farm, stre	et, factory, office	building, etc.	or Town, S	state)		Rural Route Number, City	
ospita hours uneral		4 Momicide	(0,000.0))	Outside			Internal Income	500 North Ful		<u> </u>		
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only	hysician: To the best miner:On the basis o	f examination and								
To With	₩ We	29b. Signature and title of certifi	and manner st	ated.		29c. Licen	se number		29d. l	Date signed (A	Month, Day, Year)	
		Malla	Brandle	m		O.C	.M.E.		Jun	e 1, 2010		
	1	30. Name and address of persor	who completed caus	e of death (Item 2	23a)							
		Melissa Brassell, MD	Assistant Med	0		Penn Street,	Baltimore, MI	D 21201				
Si Regis	_	31. Date filed (Month, Day, Year)	8 2010 32. Re	strar's Signature	AA	arkel						
(CI)	15:14	HIN I	OZUHE Z	المستحدث المستحدث	100	1947 CD-1						

OCME

10-03824	
Anthony Lewis	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Physician/ 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Month Anthony Lewis 0930 hrs Medical Examiner May 19, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 858 Exeter Hall Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days 214-76-0415 51 Hours Director 09/12/1958 1X M 2 F Country) Yrs Usual Residence of Decedent À 10a State 10b. County 10c. City, Town or Location 10d, Inside City Limits Health and Montal Hygiene. fitem 27 is marked other than "natural", or items 23a or 28a-f show or traumatic event, the Medical Examiner must be notified at once, Baltimore 1 X Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 858 21218 USA Exeter Hall Avenue Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 1 Never Married 2 Married Armed Forces' White, etc. 1X Yes 1 Yes 2 No specify: Black 3 Widowed Divorced If Yes, Give Year US Army Specify. ۾ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 10 Laborer Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unkn.) Edna Taylor ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Keith Robertson / Brother 2813 Gresham Way Unit 303, Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State portant: If it 1 Burial 2 Cremation 3 Removal from State crematory or other place) Final Journey Crem. 6/5/2010 Woodbine, MD 4 Donation 5 Other Specify oreral Service Lice Morota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Media Death a Atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of). Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical attending physician or use as the burial -AMENDED 23a, PII, 27, per ME G904 6/15/10 Division of Vital Records, P.O. Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown for 9 Unknown icate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Chronic alcoholism 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has performed death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) the Hospital or Attending Physician: Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient 3 DOA 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 X Natural 5 Pending 1 Yes 2 No death the Director: Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical one) 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. May 20, 2010 30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

31. Date filed (Month, 'Day, Year)

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ June 2010 Ruby Ellen Langley 5. 12:02 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Maplewood Park Place Montgomery Bethesda 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days Hours Min (Month, Day, Year) 1918 522-09-8763 Director 91 Colorado Aug. Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, <u>the Medical Examiner must be notified at</u> 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland Montgomery 1 Yes 2 X No Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9707 Old Georgetown Road 20814 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No 0. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify 3 X Widowed 4 ☐ Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "n (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Emil Frederiksen Altha Lee Mothershead and 2 should be Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9416 Talisman Road, Vienna, Virginia Richard J. Langley/Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) e 7, 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State June 2010 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Bethesda, Maryland 21. Signature of Funeral Service Licen Robert A. Pumphrey Funeral Home, Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cerebral Vascular Accident Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of cate has autonsy performed? this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) ၉ 1 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35791 June 7, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Merlyn K. Vemury, 9801 Georgia Avenue, Suite 227, Silver Spring, MD M.D. 20902 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Box 68760

Ö

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Laşt) 2. Date of Death 3. Time of Death Physician/ 7:55 M Medical Facility Name (if not institution, give street and number) County of Death
Sultimue Examiner endell If Under 1 Year If Under 24 Hrs
Months Days Hours Min. 9. Birthplace (State or Foreign Of Country) DISTRICT Of COLUMBIA **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 🏻 M 2 🗆 F Months Days 578-70-7470 56 June 9, 1953 Director Usual Residence of Decedent 28a-f show 10a. State the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's 1 Yes 2 No Capitol Heights 10e. Street and Number 10g. Citizen of What Country? Funeral 6711 Seat Pleasant Drive 20743 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cook Restaurant any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maude Benau John M. Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shabaka Tecumseh, Brother 524 North Charles Street Baltimore, Maryland 21201 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite Date 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place 06/07/10 Metro Crematory Inc. Baltimore, Maryland Signature of Funeral Service License Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications trul caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a pinsequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Exami attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death Unknown signed by the a P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician; The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 1 Yes 2 🔲 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Meatier 2 No 1 Yes nospre 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? injury 5 Pending Division 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 2010 30. Name and address of person who completed cause of death (Itom 23a) (Type, Print) bearuto State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June Physician/ Day 05 2010 Ε. Minetree 06:48 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Household of Angels Severna Park Anne Arundel If Under 1 Year If Under 24 Hrs, Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 03 1914 Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖾 F 215-28-7479 Director 95 Oct. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1473 West Cliff Drive 21122 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ☒ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White "natural", 3 ☒ Widowed 4 ☐ Divorced Completed Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Homemaker 12 Household other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ည Francis Edwards Blanch Bowen if. Page 1 and 2 shour.
To fleath and Mr.
To fleath and Mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John "Jack" Klovstad 1473 West Cliff Drive, Pasadena, (son) MD 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 A Cremation 3 Removal from State Metro Crematory Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) 2010 21. Signature of F neral Service Licens 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 23a. Part 1. Enter the diseas Part 1. Enter the disease or complications hat c shock, or heart failure. List only one cause in each ne the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final ARTERIOSCLEROTIC VASCULAR DISEASE Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last signed by the attending physician is be detached for use as the board. Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ALZHEIMER 2 No 3 Probably 4 Unknown 1 Yes After this certificate has been CHRONIC OBSTRUCTIVE LUNG DISEASE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner?

1 Yes 2 \(\square\) No 26. Place of Death (Check only one) Be ASSITED Hospital: Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury 5 Pending Accident Investigation after death Director: / 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral D

completed filled i 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifig 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

3/00 LORD BALTIMORE DR #110 BALTIMORE MD 2/244

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2018 JUNE Medical 4a. Facility Name (if not institution, give street and number) Location of Death 4c. County of Death Examiner Jf Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ★ M 2 □ F Months Days Hours Min. 09/20/ Maryland 213-86-9827 Director 43 Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director notified 1 Yes 2 No MD Baltimore Co. Owings Mills 10e. Street and Number 10f. Zip Code r must be r ŏ 10g. Citizen of What Country? Funeral 9233 Amber Oaks Way 21117 items ; Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner on ury or other traumatic event, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. δ 1X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 10th Grade College (1-4 or 5+) Mover U-Haul Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Howard Montgomery Barbara Pender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Alford(sister) 9233 Amber Oaks Way, Owings Mills, MD 21117 Department of Health Important: If item 27 any injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
And The Hardy F/H 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State 106/08/10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service License Hrulfown Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Yes 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 **W**No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred Natural work? injury 5 Pending Investigation Could not be 2 🗆 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature

Registrar

DHMH 17 Rev 7/2009

State

Name and address of person who completed cause of death (Item 23a) (Type, Print)

K.B. Kovica, 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Wonth 20 10° Regina Marie Mahon 01 03:10 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death st. Agnes HOS Aita 13al timore Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Date of Pay, Pay, 1 🗆 M 2 🔀 F Days Hours Min. 214-26-1714 Director 79 **1**930 Marvland Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10c. City. Town or Location with the Maryland be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 23a 7 Sharonwood Court 21228 USA event, the Medical Examiner must or items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 hours after White 1 ☐ Yes 2 A No Specify: Ves Give 'natural", Specify: 3 Midowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Clarence Charles Bruns Mary Margaret Schultz permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharonwood Court; Catonsville, MD 21228 Mary C. Fox Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery 6/5/2010 Baltimore. MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signa ure of Funeral Service License. 21228 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that cabsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List entry one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death uro setsis Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown should be detached for Month Pregnant at time of death 5 Other (specify) 9 Unknown Records, P.O. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 2 No 3 Probably 4 Unknown uctile fulmonary 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 1 ☐ Yes 2 ☐ No or Attending Physician: the funeral director, 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 🗌 Yes within 24 hours after death

To the Funeral Director: A
completed filled in by the fi death Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a, Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, To the P only one) and title of certific 29b. Signature 29d. Date signed (Month, Day, Year) 3 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) AVE: BALTIMORE MI 900 MOLALES MOTA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

VEGINA

MARON

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 May 30 4:15 P^{M} Josephine Duval McCollister /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery General Hospital 01ney Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🛛 F 215-48-2706 Yrs. 83 **Director** July 29, 1926 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If them 27 is marked other than "natural", or items 23a or 23a-f show ant: If and 17 is marked other than "natural", or other traumatic event, the Marical Expurime mast be exitted at any or other traumatic event, the Marical Expurime mast be exitted at 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Director Maryland Silver Spring <u>Montgomery</u> 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 United States 3700 International Drive Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Jay Gould McCollister Mary C. Harley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Silver Spring, MD 20906 Anne H. Wilson/Sister 3701 International Dr. #731, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If II any injury or c 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5 June 2010 St. Mary's Catholic Cemetery Petersville, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility.
Robert A. Pumphrey Funeral Home, Rockville, Inc. Houm M01530 300 West Montgomery Avenue, Rockville, Maryland, 20850 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** arlis polingion disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Failure Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed Hypotewian attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes → No 24a. Was an nis certificate has director, page 2 autopsy perform 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∏Yes 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Alatural 2 Accident 5 Pending investigation ours after death.

Ieral Director: Aff
filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 D68618 Name and address of person who completed cause of death (Item 23a) (Type, Print) Alex Kinngird General

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	tate of Marylar		artment of H			7.0	10	7821			
			Registrar 1. Decedent's Name (First, Middle, Last)				Journ	2. Date of Dea	Reg. No.		3. Time of Death			
	Physic		Martin Thai	Stewart	McGrei	WW		June Month	6 Day	2010	11:31 PM			
	Med Exam		4a. Facility Name (if not institution, give stree			4b. City, Town, or	Location of Dea			ty of Death	11.51 F			
_/	LXaiii		Suburban Hospital			Bethesd	la			tgome	ry			
	Funera Directo		5. Social Security Number 6. Sex 1 X M	2 ☐ F 7. Age (In yrs. 43	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		r 8 1966		olace (State or Foreign try) C ornia			
	MC ,		Usual Residence of Decedent											
	yland f sho ed at	5	10a. State 10b. County		ity, Town or Lo					1	0d. Inside City Limits			
	Mar 28a- notifi	Director	Maryland Montgomer	У		Bethesda					1 🗌 Yes 2 ី No			
	10g. Citizen									f What Country?				
	th wi	7108 Exfair Road 12. Was Decedent Ever in U.S. 13. Was Decedent Flyspanic Origin? (Specify Yes or No-												
	r dea			Armed Forces?	.S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (3 n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ice - Americ ack, White, e				
980	s afte ral", c	Specify: Specify:									hite			
Õ	hour natur Jical	l se	15. Decedent's Educat	ion		ent's Usual Occupa			16b. Kind of	Business Inc	dustry			
21215-0036	in 72 e. han "	Į	(Specify only highest grade of Elementary/Seconday (0-12)	College (1-4 or 5+)	life. De	kind of work done d O NOT use retired)	uring most of w	orking	10					
7	ygien ygien her ti	Be C		5+	Phys	sician			Hos	pital				
Maryland	e filed htal H ed ot	10 B	17. Father's Name (First, Middle, Last) Denis McGreivy					ame (First, Middle,		ne)				
ž	d Mel d Mel mark matic	- 1	19a. Informant's Name/Relationship (Type, F	Suit on 41	T			n D. Gra						
Ma	2 sho Ith an 27 is trau		Katherine A. Bradley	,		g Address (Street a Exfair Ro								
<u>ē</u>	f Heal		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		Date Date	20c. Location					
m 0	age ent o nt: If		1 ☐ Burial 2 🛣 Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State Mon	cemetery, cren teomery (natory or other place Crematorium	Jun June 20	e 8,		•	laryland			
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral & rvice Licensee	4	RO		· ; 2.0				Chase, Inc.			
	HO = 6 0		200 Part Floring disease or complicate	· w	303 1/5	5/ Wisconsi	<u>n Avenue, </u>	Bethesda,	Marylan	d 20814	-3501			
1		Į,	23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca Immediate Cause (Final	use on each line.					rest,		Approximate Interval Between Onset and Death			
	-hysician. ⊢ Medica		disease or condition resulting in death)	myoca	rda	e in	fanc	tion		- 1	Onset and Beating			
	Examine	_		Du m (or as a conseq	quence ot):						a. M			
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	quence of):					- 5				
	ate be executed physician and the burial-transit	xam	Cause (Disease or iinjury that initiated events c	Due to (en en e energe										
_	oe exe	dical E	resulting in death) Last	Due to (or as a conseq	quence or):									
760	phys phys the I		d											
89	eath certifica attending p	\\	IF FEMALE: 23b. Was decedent pregnant 23c.	f yes, outcome of pregn					23d F	ate of delive	en/			
Box 687	eath eath	Sicia	in the past 12 months?	1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of		Ectopic pregnanc Other (specify)	у			onth long	Day Year			
П	requires that the de been signed by the should be detached	Physician/Me	9 🗌 Unknown	9 Unknown										
P.O.	s that gned se def	2	Part II. Other significant conditions contrib	uting to death but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did to			ne cause of death?			
'ds	equire	ted 6						. 10	Yes 2 No	3 🗆 Prol	oably 4 🗆 Unknown			
Ö	has be	Completed						24a. Was autor	osy	prior to co	osy findings available mpletion of cause of			
Re	ician: The k certificate har rector, page							perfo 1 ☐ Yes	rmed? 2 JK No	death?	2 □ No			
ta	sician: The certificate rector, pag	~ \ &	25. Was case referred to medical examiner?	ital:	111		ace of Death (Ch	eck only one)						
Ξ	Physical this call dir.		1 Yes 2 No	1 Inpatient 2			4 ☐ Nursing	Home 5 Resid)			
0 0	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and complete dilled in by the funeral director, page 2 should be detached for use as the burial-transition. The following the formula of $\frac{1}{2} \int_{-1}^{1} \int_{-1}^{2} \int_{-1}^{1} \int_{-1}^{1} \int_{-1}^{1} \int_{-1}^{2} \int_{-1}^{1} $	Certificate:	Natural 5 Pending	8a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work'	rat ? Yes 2 □ No	28d. Describe h	ow injury occu	rred				
sio	Atten r deat ctor: by the		3 Suicide 6 Could not be	8e. Place of Injury - At h	ome, farm, stre		165 2 110	28f. Location (S	Street and Num	ber or Rural	Route Number			
Division of Vital Records,	s after al Direct by a line by		4 El Homicide determined	building, etc. (Specif	5y)			City or Tow						
	To the Hospit within 24 houn To the Funera completed fille	edical	29a. Certifier 1 Certifying Physician (Check 2 Medical Examiner:	: To the best of my know	vledge, death o	ccured at the time,	date and place,	and due to the car	use(s) and man	ner as state	d.			
	ithin 24 orthe Formplet		only one) 3 L Certifying Nurse Pro	actioner: To the best of m	ny knowledge, o	leath occurred at the	time, date and p	place, and due to the	e cause(s) and r	nanner as st	ated.			
_	5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-	29b. Signature and the of continer	in the second		29c. License			29d. Date sign 6 / 6		Day, Year)			
J	/ 8	6	MA				2153	>	0/6	110				
10	ο √ ξ		30. Name and address of person who comp Amirali Nader, M.D.	eted cause of death (Iter		,	Betho	sda More	71 and 20	081 <i>h</i>				
		- 1					, 200116	July Hall	- LUIIU 2	O T 4				
	St	ate	31. Date filed (Month, Day, Year) JUN 0 8 201	32. R gistrar's Signa	ature	harles								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend item 18 perfh g904 6-9-10 vt.
State of Maryland / Department of Health and Mental Hygiene 0 1 7822

		1 - State Registrar		C	ertificate of	Death		Reg. No	o.	هدره مهادة الي
Physic	ian/	1. Decedent's Name (First, Middle, Last	t)				2. Date of De		ay Year	3. Time of Death
	dical	Julia F.	Nawrot				June	7	2010	12:40A M
Exam	iner	4a. Facility Name (if not institution, give	·			or Location of Deat	th	40	. County of Death	
Funer	7	Carroll Hospit 5. Social Security Number 6. Se		In yrs. last birthda		minster If Under 24 Hrs	8. Date of Bi	dh_	Carro	11 place (State or Foreign
Funera Directo			. 67	32 Yrs	Months Days			2 ⁽¹⁾ 2 ⁽²⁾ 28 ⁽²⁾	Mary	rland
d tow	٦.	Usual Residence of Decedent 10a. State 10b. County	1.	I Oc. City, Town or	Location					I 0d. Inside City Limits
ırylan 1-f sh ied a	Director	Maryland Baltimor		,						1 ☐ Yes 2 🔯 No
or 28g	Pig	10e. Street and Number	Le	OWIII	gs Mills 10f. Zip Code			10~ 0	itizen of What Cour	
with the 23a c	Funeral	4706 Deer Park Roa	ad		1011 215 0000	21117			ited Stat	•
eath tems er mu	Ë	11. Marital Status	12. Was Decedent Eve	er in U.S.	Was Decedent of H If Yes, specify Cubi		pecify Yes or No-	_	14. Race - Americ	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at	d by	1 ☐ Never Married 2 ♣ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give	0	1 Yes 2X No		to Rican, etc.)		Black, White, Specify: Whit	
hours	ete	15. Decedent's Ed		16a. De	cedent's Usual Occup	oation	_	16b k	Kind of Business In	
215	Completed	(Specify only highest grade	de completed) College (1-4 or 5+)	(G	ve kind of work done . DO NOT use retired)	during most of wo	rking	100.1	VIII OI DUSITIESS III	dustry
21. Within within a sign of the sign of th	ပြိ	12 years		Un	it Secreta	ry		Si	nai Hospi	tal
ind e filed tal Hy ed oth	To Be	17. Father's Name (First, Middle, Last)					me (First, Middle		•	
ryla uld be 1 Men narke	-	Clarence Anthony		<u> </u>		Gladys	Sehut			
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", o traumatic event, the Medical Exam		19a. Informant's Name/Relationship (Type Lisa Nawrot (I	oe, Print) Daughter)	- 1	ailing Address (Street 7 Abell Av					Code)
Te, 1 and 1 Hea of Hea other		20a. Method of Disposition		20b. Place of Di	sposition (Name of		Date		ocation - City or To	own, State
Page nent c		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			rematory or other place ew Mem. Pk		-2010	Sky	esville,	MD
Baltimore, bermit. Page 1 and Department of Heal Important: If item 3 any injury or other	2	21. Signature of Funeral Service License	ee A	/_	22. Name and Addre	ess of Facility	11824		terstown	
ಟ ಪ∆೬೯ರ	5	Sopherm	Lenk	ins	Eline Fund				wn, MD 2	1136
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the cause on each line.	ne death. Do not	enter the mode of dyir	ng, such as cardiad	or respiratory a	rest,		Approximate Interval Between
Physician Medica		Immediate Cause (Final disease or condition resulting in death)	a. ileuc	-						Onset and Death
Examine			A '	onsequence of):	1 C 1	.0				
	ner	if any, leading to immediate	b. Due to (or as a c		1/41/01					
uted id ansit	ami	cause. Enter Underlying Cause (Disease or iinjury that initiated events	. Dehi	rdrahk	>~				5.7	
. 68760 certificate be executed nding physician and use as the burial-transit	Medical Examiner	resulting in death) Last	Due to (or as a c	consequence of):						
8760 tificate be ng physic as the bu	di Sign		d							
687 ertifica ding p		IF FEMALE:	23c. If yes, outcome of	pregnancy						-
Box death o he atten ed for us	ciar	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth 2 4 Pregnant at ti	□ Fetal death	B	су			23d. Date of delive Month	ery Day Year
ords, P.O. Box 6 requires that the death cer been signed by the attendi should be detached for use	Physician/	9 Unknown	9 Unknown							
that the need by the detach	by P	Part II. Other significant conditions con	ntributing to death but	not resulting in th	e underlying cause gi	ven in Part I.	23e. Did t	obacco i	use contribute to th	ne cause of death?
ords, requires been sign	ed						1 🗆	Yes 2	3 ☐ Prol	oably 4 🗆 Unknown
VITAI KECOTGS, systoian: The law requires is certificate has been sig director, page 2 should b	Completed						24a. Was		24b. Were autoprior to co	psy findings available mpletion of cause of
He the	Son						perfe	ormed?	death?	·
tal cian: ertific	Be	25. Was case referred to medical examiner?	lospital:			lace of Death (Che	ck only one)			
Physi Physi this c	12	1 Yes 2 No	1 Inpatient	28b. Time		4 ☐ Nursing F			3 ☐ Other (Specify)
DIVISION OF tal or Attending PP rs after death. al Director; After the	Certificate:	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,)	/ear) 200. Tille	/ work	yat k? Yes 2 □ No	28d. Describe I	now injur	y occurred	
Atten Atten er dea ector; by the	ij	3 Suicide 6 Could not be	28e. Place of Injury		street, factory, office	100			d Number or Rural	Route Number,
DIV ital or its after al Dir			building, etc. (City or Tov			
DIVISION Of VITAI HECC To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 v	Medical	(Check 2 \(\subseteq \text{Medical Examin} \)		mination and/or in	restigation, in my opinie	on, death occurred	at the time, date a	and place	e, and due to the cal	use(s) and manner stated
o the o the omple	ž	only one) 3 L Certifying Nurse 29b. Signature and title of certifier.	Practioner: To the be	st of my knowledg	e, death occurred at the 29c. License		ace, and due to the		s) and manner as sta et e signed <i>(Month, I</i>	
PSFO		1 Chlu	1000		21.	2716		6	17/10	ous, rour,
6v		30. Name and address of person who co	empleted cause of deal	th (Item 23a) (Type		2 ()			1110	
WV		Thomas Ven			ness Ch	Dr. 1	Keisters	town	a pro c	21136
St Regist	ate	31. Date filed (Month, Day, Year)	32. Registrar's	Signature						
i logisi		IIIN 0.9 201			50.00 S					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Catherine June Naghdi 2010 12:12 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel General Hospital Annapolis Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 8. Date of Birth 1 M 2 F Months (Month, Day, Year) Aug. 03 1943 Days Hours Min. **Director** 219-40-5653 66 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic events. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel 1 Yes 2 X No Millersville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1009 Lamp Post Lane 21108 USA 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 ☑ No Specify: Completed 3 Divorced Specify: Year or Dates white 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Social Security Admin Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Joseph Ε. Osborne Catherine Moran 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael M. Naghdi (spouse) 1009 Lamp Post Lane, Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 Cremation 3 Removal from State June 12 4 Donation 5 Other (Specify) Metro Crematory Inc. Baltimore, Maryland 2010 21. Signatur of Funeral Service Lc 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD Part 1. Enter the disease, or complic shock, or heart failure. List only one ediate Cause (Final 23a Part 1 Enter the di that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician, Myo cardia Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the attending physician and ched for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year g 🗌 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Kunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 X No 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Matural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a 29a. Certifier K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge death occurred at the time date and place and out to the cause(s) and manner stated. (Check only one diat the time date and place, and dusito the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) reulbun, My D46052

Registrar DHMH 17 Rev 7/2009

State

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ireal Buch, MD

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death L. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Michael Marshall 2010 3:45AM Newton June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Co. 24 Holloway Road Glen Burnie 8. Date of Birth (Month, Day, Year) Sept. 6, 1950 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Davs Hours Min. Maryland 59 Sept. Director 217-56-4384 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Glen Burnie MD Anne Arundel Co. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21060 United States 24 Holloway Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sears Dept. Store 12 <u>Accountant</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Audrey Mary Johnson Reginald Howard Newton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Kevin L. Newton / Brother 21037 Edgewater, Maryland 1732 Quantico Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 06/07/2010 4 Donation 5 Other (Specify) Glen Burnie, MD Atlantic Crematory 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Se Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to or as a consequence of it any leading to in medicine cause. Enter Underlying Cause (Disease or iinjury that initiated events **To the Hospital or Attending Physician**: The law requires that the death certificate be execu**f**ed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Polio 2 🖾 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform rmed? 2 No 1 Yes 2 No neral Director: After this certificate I filled in by the funeral director, page 1 Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မှ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 26 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jack Bufford Neal Mav 6:25 PΜ Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Country)Unk **Funeral** Days 1 X M 2 A F Hours Min. 411-54-6720 76 March, Day, Year 934 **Director** Usual Residence of Decedent or 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits . Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director Frederick 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 200 E. 16th Street 21701 USA 12. Was Decedent Ever in U.S. Armed Forces?unk 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status unk Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify.White 1 ☐ Yes 2 K No Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Unk (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry unk (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meany injury or other traumatic event, the Mean any injury or other traumatic event, the Mean and injury or other traumatic event, the Mean and injury or other traumatic event. Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Neal/wife 465 W. South Street; Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Aphther (Specify) in state Signature of Euneral Service Licensee ²² Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Director Raltimore, Maryland Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock or heart failure. List only one cause on each line Amyo hophic Lateral Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical s a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): ulor Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🔲 No 2 N Division of Vital 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined City or Town, State) 24 hours Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chec To the I within 24 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature

Name and add

RAVEEY 31. Date filed (Month, Day

of certifier

PEEDELICE, 7D

ss of person who completed cause of death (Item 23a) (Type, Print)

Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Edison Pumell 4:05AM homas 2010 June /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Genesis Nursing Home - Randallstown Kaltimore Kandallstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 220.26.1584 1 M 2 □ F Months. Days Hours Min Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Modeal Examiner must be notfilled Director Baltimore Windsor Mill 1 ☐ Yes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Wild Chemi 21244 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify. þ Specify: Back 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) University of d 2 should be filed within th and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) EEG lechnician Maryland years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allene eshields aymond Durnell Pages 1 and 2 should မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 bepartment of Health an Important; If item 27 is any injury or other trauone. Road Windsor Mill, MD 21244 Purnell Wild Cherry lean 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6/11/2010 Garrison Forest 4 Donation 5 Dother (Specify) Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaugan C. Greene Funeral Services Vau Road Pandaubtown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arcest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0250 Merch /Medical Due to (or as a consequence w) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-tran resulting in death) Last Due to (or as a consequence of): physician Be Completed by Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached for 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? G 12 1 3 Probably 4 Unknown 1 ∏Yes 2 ∏No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate 1 □ Yes funeral director, 25. Was case examiner? referred to medical 26. Place of Death (Check only one Hospital: Other: Certification: To 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Sursing Home After this 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital within 24 hours a To the Funeral D the Hospital Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760

Division of Vital Records,

Registrar

31. Date filed (Month, Day, Year)

32. Registrar Signat

30. Name and address of person who completed cause of death (Item 23a) (Ty

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:10KM Audrev Palmer 2010 Medical Tune 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Town, or Location of Death Baltimohe Hosb da ocial Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months 1 □ M 2 🔽 F Hours 05-02-1936 Maryland 215-30-2204 Director 74 Usual Residence of Decedent fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at 00.09. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1350 Chesaco Avenue, Apt 314 21237 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 X No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Vernon LeRoy Grimes Daisy Beatrice Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence K. Palmer - son 106 Morgan Elis Way, Baltimore, Maryland 21206 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗋 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Pk. 06-07-2010 Elkridge, Maryland 21. Signature of Funeral Service Lisensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Inc.,7250 Wash. Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death ₽¹ıysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ertension the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death signed by the a 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Tyes Investigation Could not be within 24 hours after death

To the Funeral Director: / Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

10-04003 Bertha Pfleegor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. O State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Ce	rtifica	ate of	Deati	h				Reg. No	0.		
Physic	an/	Decedent's Name (First, Midd	lle,Last)					_			2. Date of D	eath			3. Time of Death
ledical Exam	iner	Bertha Pfleego	or								Month May 23,	2010	Year		0900 hrs
		4a. Facility Name (if not institution	on, give street and nu	umber)		41	b. City, T	own, or	Location	of Death	1	·	4c. County of	f Death	
		144 Washington Roa	d				Edge	water					Anne Aru		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birth	nday)	If Unde	er 1 Yea	r If Unde	er 24Hrs	8. Date of	Birth (M	M/DD/YYYY)	9. Birt	hplace (State or n Washingtor
Director		213-34-2288	1 M 2 X F	71		Yrs.	Month	s Day	s Hours	s Min	Sept	12.	1938	Foreig Cou	into/)
		Usual Residence of Decedent				_			1			,			DC
any		10a. State 10b. County		10c. City,	, Town o	or Locatio	n				· · · · · ·				10d. Inside City Limits
p e		MD Anne	Arunde1	Edg	gewa	ter									1 Yes 2 No
Maryland 28a-f show any d at once.	양	10e. Street and Number				- 1	10f. Zip	Code				10a C	itizen of Wha	at Cour	try?
ith the Maryland 23a or 28a-f sho notified at once	Director		D 1			l	•								,
ith th		144 Washingto		cedent Ever in U	c 1	12 Was		037	anda Odi	-:-0 / C	if . V		SA	A	Indian Diani
ath w tems	Funeral		arried Armed F	orces?	.3.						pecify Yes or l Rican, etc.)	40-	White,		can Indian, Black,
erde , or i	Fu	3 Widowed 4 St Div	1 Yes	2 🔀 No		4 m	V 1	TT No	specify:				Cassif :: T	- L	
rs aft nral" mine	by	15. Decedent's Education (Spe	or Dates:		160 5				tion (Give		wark dana	16h	Specify: V		ndustry unk
hou "nat	ted	Elementary/Secondary (0-12)							DO NOT			100	. Killa of bas	111622/11	idusii y LIIK
)36 thin 72 than than edical	ompleted	12	0	1-4010.7	- a	ispa	taha	20							
-00 l with giene ther t	E O	17. Father's Name (First, Middle			u	тора	cene		18 Mother	r's Name	(First, Middle	Maide	n Surname)	-	
115.	Be C	James Arthur						ŀ			Virgini				
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica	0 8	19a. Informant's Name/Relations			19b	. Mailing /	Address	(Stree			Rural Route N			State	Zin Code)
MD de 2 shot lith and lith and list and	_	Robin Cain/d									othian,		•		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygien the Maturial", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	1 8	20a. Method of Disposition	augneer	20b. l		Dispositi				,	Date		Location - (
Ore		1 Burial 2 Cremation	3 Removal fr	om State	cremato	ry or othe	r place)							•	
tim Fag Ement tant		4 X Donation 5 Other S		7											
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours afte begarment of Health and Mental Hygener. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		21. Sign no of Funeral Service Ronald S	Licensee	irector		22. Na S t	me and / ate	Address Ana	of Facility	^y Boa	rd: 65	5 W.	Balt:	imoı	re Street
	1 2	23a. Part I. Enter the disease, or	// ** ** // /	1											
Physician /Medical		failure. List only one cause	on each line.	aused the death.	. Do not	enter the	mode o	f dying.	such as c	ardiac o	r respiratory a	rrest, sh	nock, or hear	t	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease				eroso	cler	otic	car	diov	ascula	r d	isease	2	Death
		or condition resulting in death)	Due to (or as a	consequence o	f):										
	7	Sequentially list conditions,	D. Thus to for me n	consequence o	re:										
	miner	cause. Enter Underlying Cause	С.	ooneoquenec o	17-									1	
n .ii	Exan	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	f):										
ecuted and transit			¬ d												
760, cate be execut physician and he burial - tra	gi	X UNPENDED AMENDED 23a, PII, 27, per ME g905 7/22/10 TT													
760, ficate be ex g physician the burial	/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes,	outcome of pregi	nancy							23	3d. Date of d	elivery	
OX 68's sath certification attending for use as 1	ian	past 12 months?	Line	irth ant at time of de		=			Ectopic	c pregna	incy		Month	D	ay Year
Box 68 e death certif the attending	Physician	1 Yes 2 V No 9 Uni	known 9 Unkno		ath 5	Othe	er (Speci	ify) _							
by the ched f	P.	Part II. Other significant condit	ions contributing to	death but not re	esulting	in the und	derlying	cause o	iven in Pa	art I.	23e. Did	tobacco	use contrib	ute to ti	ne cause of death?
, P.O. res that the signed by be detach	þ	Diabetes me									1 🗆 Y	es 2	No 3	Proba	ably 4 🗸 Unknown
rds, require been si	Completed										24a. Wa	s an	24b. W	ere aut	opsy findings available
Sorce law re has be	ple										aut	opsy ormed?	pri		empletion of cause of
Records, The law requir ficate has been si	Ö										1 Yes	2 1	No 1	✓ Yes	2 No
tal Rectian: The certificate ector, page	Be (25. Was case referred to medica examiner?					2		of Death ((Check	only one)				
of Vital ng Physician: After this certi	၀	1 Yes 2 No	Hospital: 1 1	npatient 2	ER/Out	tpatient	3 DC	DA	Other4	Nursin	g Home 5	Resid	ence 6 🗸	Other:	Scene
of ing Pl After unera	n: T	27. Manner of Death	28a. Date (Month	of Injury , Day,Year)	28b. T	ime of Inju	ury 28	8c. Injur	y at Work	?	28d. Describe	how in	jury occurred	4	
ion tendi for:	ati.	= Pend	ling stigation					1 Y	es 2	No					
Division tal or Attendir s after death. al Director: A led in by the fu	iţi		28e Place	e of Injury - At ho	ome, fan	m, street,	factory,	office b	uilding, et	C.			and Number	or Rura	al Route Number, City
AMENDED AME											or rown,	State)			
							d at the t	time, da	ite and pla	ce, and	due to the car	use(s) a	nd manner a	s state	d.
							n, in my	opinion,	, death occ	curred a	t the time, dat	e and pl	ace, and due	e to the	cause(s)
								29d.	Date signed	(Mon	th, Day, Year)				
		Colun	un	>1		~		O.C.	M.E.			Ма	y 27, 201	0	
_		30. Name and address of person	who completed caus	se of death (Item	23a)										
		Zabiullah Ali, M.D.	Assistant Medic	al Examiner	111	1 Penn	Street	, Balti	more, N	/ID 21	201				
S	tate	31 Date filed (Month, Day Year)	32. Re	strar's Signatu	re										
Regis		O NUL	8 2010 /	Vieres .	19	has	a select								

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

_				State of Maryla		artment o <i>rtificate d</i>			giene Reg. No.	10	17829	
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	PALM	ER			2. Date of De Month	Day	/Year	3. Time of Death	
1	Exami		4a. Facility Name (If not institution, give s	ŕ			4b. City, Town, or CUMBE			y of Death	wy	
	Funeral Director		5. Social Security Number Unk 6. Sex	M 2□ F 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Ye Months Da		(Month, Da	th <i>y, Year)</i> 25 , 1944	9. Birthpl Count	ace (State or Foreign tryUNK	
	e Maryland a-f show	ctor	Usual Residence of Decedent		ity, Town or Lo					10	0d. Inside City Limits 1 ☐ Yes 2X No	
	with the	Dire	10e. Street and Number			10f. Zip Cod	е		10g. Citizen of	What Count	ry?	
020	within 72 hours after death with the Maryland ene. than "natural, or items 23a or 28a-f show the Medical Exerciter roust be notified at	by Funeral Director	13800 McMullen Hi 11. Marital Status unk 1 Never Married 2 Married 3 Widowed 4 Divorced	ghway Southw 2. Was Decedent Ever in U Armed Forces? unk 1						USA 14. Race - American Indian, Black, White, etc. Specify.white		
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natur any finjury or other traumetic event, tra Medical once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) unk	Jucation (Give kind of work infe. DO NOT use unk			cupation unk ne during most of woi ired)	16b. Kind of Business/Industry UNK				
yland	ould be file Mental Hy arked other atic event	To Be (17. Father's Name (First, Middle, Last) 1	ınk			18. Mother's Nar	ne (First, Middle,	Maiden Suma	me) unk		
e, Mar	and 2 sho leafth and m 27 is ma		19a. Informant's Name/Relationship <i>(Typ.</i> Captain Robert T	ichnell			orrectiona J; Cumberl	ural Route Number l Instit and, Mar	er, City or Town ute; 1 yland 2	, State, Zip 1800 M 1502	^{Code)} cMullen	
timore	. Pages timent of Hisant: if iteliury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Place of Dispo cemetery, crer	sition (Name of natory or other	place)	Date	20c. Location	- City or Tov	vn, State	
Ba	permit Depart Import any in		21. Signature of Funeral Pergices icense	ade Directo			dress of Facility Itomy Boar e, Maryla			lmore	Street	
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ANOXIC		RAIN			rrest,		Approximate Interval Between Onset and Death	
, 68760,	rificate be executed og physician and as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
s, P.O. Box	The law requires that the death cer ate has been signed by the attendin page 2 should be detached for use	by Physiclan/M	Part II. Other significent conditions cont			nderlying cause	given in Part I. Y 015CP4-5	10	tobecco use co Yes 2□ No	ontribute to	the ceuse of deeth?	
Vital Records,	he law requir e has been si age 2 should	Completed	DIABETES A	recity	Typ	ピン		perfo	an autopsy rmed?	ava com of d	re autopsy findings ilable prior to npletion of cause leath?	
ıta	ian: T	BeC	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only o	1	1	lYes 2□ No	
o	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	၉	1 Yes 2 No Ho 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Ir		ome 5 ☐ Resid		ner <i>(Specify,</i> rred	WUI	
DIVISION	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Specif	(y)			28f. Location (S City or Tox	vn, State)			
	ne Hos n 24 hc ne Fune	edical	29a. Certifier (Check only one) Certifying Physical Exemine	clen: To the best of my kno er: On the basis of examina and manner stated.	wiedge, death tion and/or inv	occurred at the estigation, in m	time, date and place y opinion, death occu	, and due to the or rred at the time,	cause(s) and m date and place,	anner as sta and due to	ited. the cause(s)	
	To the Comp		29b. Signature and title of certifier			29c. Lice	nse number		29d. Date sign	ed (Month, E	ay, Year)	
			30. Name and address of	ma	- 00-1/7	<u> </u>	,2294		6/2	10		
			30. Name and address of person who con	mp death (Item	n 23a) (Type, I 3 800		ULLEN	1+19HW	ay,	4D2	-1502	
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registrat's Signa	ature &	6-46						

DHMH 16 Rev 6/95

faced to me Inc

		For	State o	of Marylan	•			and Mental	Hygier	ne			
		State Registrar			Cer	tificate of	Death		Reg.	No?	10	1783	10
Physician	n/	1. Decedent's Name (First, Middle,	,					Mont	of Death h	Day 5	Year	3. Time of Deat	
Medica Examine		DORIS PRES 4a. Facility Name (if not institution,	SSMAN give street and num	nber)		4b. City, Town,	or Location o	of Death		4c. County	2.010	1:41/	
) Examine	GI.	SINAI HOSPITA			E	BALTI				4c. County	N/A		
Funeral			6. Sex 1 □ M 2 X F	7. Age (In yrs. la 81		If Under 1 Year Months Days			of Birth	к)	g. Birthp Count	lace (State or For	'eign
Director	H	220-20-8984 Usual Residence of Decedent	, X , ,	01	Yrs.			p2706	71929	<i></i>		NY	
and show	ě	10a. State 10b. County		10c. City	y, Town or Loc	ation					1	0d. Inside City Lin	nits
Mary 28a-f otifie	rec	MD BALT	IMORE			BALT IMOR	E					1 🗆 Yes 2 💢] No
h the la or j	9	10e. Street and Number				10f. Zip Code			10g.	Citizen of	What Coun	try?	
th with ms 23 must	Funeral Director	7218 PARK HEIGH			Lieu	21208		1000 100			USA		
r dear	F.	11. Marital Status1 ☐ Never Married 2 ☐ Marri	Armed Fo	edent Ever in U.S				gin? (Specify Yes o , Puerto Rican, etc			e - America ck, White, e		
s afte ral", c	ed by	3 X Widowed 4 □ Divorced	If Yes, Giv Year or Da	re .	1	☐ Yes 2 X XN	o Specify:			Specify	: Wi	HITE	
hour natu	plet	15. Deceden	t's Education st grade completed)			ent's Usual Occu		of working	16b	. Kind of B	usiness Ind	ustry	=
hin 72 ne. than '	Completed	Elementary/Seconday (0-12)	College (1		Ìife. DC	NOT use retired		or working		OWN H	OME		
ad with Hygie other ant, the	a l	17. Father's Name (First, Middle, La	ast)		ПОМІ	EMAKER	18 Mothe	er's Name (First, M					
be fill lental rked c	[의		SHAP I RO				SARA	, ,			RSTEI	N	
should and N is ma	1	19a. Informant's Name/Relationsh						r or Rural Route N	umber, City	or Town, S	State, Zip C		
nd 2 s lealth m 27 her tra		HOWARD PRESSMAI	1/SON				ROAD,	, EDGEWAT					
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation		State RFT	lace of Dispose emetery, crem	sition (Name of atony or other pla - MORT AT	BARK (Date 06/06/201	20c		- City or To LSTOW		
artmer artmer ortant injury		4 Donation 5 Other (S)		1			- :						
Depi Imp		De SuetVIII	With	1	8	900 REIS	TERST	SOL LEVI OWN ROAD	PIK	(ESVII	JS., _LE,	MD 21208	, id
		23a. Part 1. Enter the disease, or shock, or heart failure. List or										Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition			YOCA	RDIAL	INFA	ARCTIO	2			Onset and Death	1
Medical Examiner		resulting in death)	Due to	(or as a consequ	ience of):								
	ē	Sequentially list conditions if any, leading to immediate	. Ur management	CHEMI (or as a consequ		OWEL	DISE	ASE			- 2	co day.	<u> </u>
ted d ansit	Examiner	cause. Enter Underlying Cause (Disease or linjury		(0) 40 4 00110040	.51155 51).								
be executed sician and burial-transit	Ĕ	that initiated events resulting in death) Last	Due to	(or as a consequ	ience of):								
ate be hysici the bu	dical	'	d										-
ding p	Me	IF FEMALE:	23c. If yes, out	come of pregna	ncv					004 0	to of dollar		
atten atten for us	ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	1 Live		ıldeath 3 ⊑	Ectopic pregnar Other (specify)	псу				ite of delive onth	ry Day Year	
the de by the ached	Physician/Me	g Unknown	g □ Unkr	nown									
s that gned i	by	Part II. Other significant condition				, ,						e cause of death?	
equire een si rould l	Completed by	HYPERTENSIO	N, DIA	IBETES	PER	CIPHER	LINEL						
law re has b	d m	DEMENTIA						24a.	Was an autopsy performed		Were autop prior to cor death?	sy findings availa npletion of cause	able of
r: The licate r, pag		25. Was case referred to medical	3						Yes 2		1 🗆 Yes	2 No	
siciar certifirecto	m	examiner?	Hospital:	Inpatient 2 🗆	ED/Outpation	I Ot	her	th (Check only one)		. C □ O#	(0:4.)		
g Phy er this ieral d	e: To	27. Manner of Death	28a. Date		28b. Time of	28c. Inju	ıry at			jury occur			
eath. or: Aft	licat	1 Natural 5 Pending 2 Accident Investig	ation	iii, Day, Tear)	injury	M 1 [Yes 2	No					
or Atter de lirecton by the	Certificate:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi	28e. Place	of Injury - At ho ng, etc. (Specify	me, farm, stre	et, factory, office			tion (Street or Town, St		er or Rural	Route Number,	
spital o		29a, Certifier 1 Certifying	Physician: To the b	est of my knowl	edge death o	ccured at the tim	e date and r	place, and due to t	he cause(s	and mann	er as state	1	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Ex	xaminer: On the bas Nurse Practioner:	sis of examination	n and/or investi	gation, in my opir	ion, death oc	curred at the time,	date and pla	ace, and du	e to the cau	se(s) and manner	stated.
Vithi To th		29b. Signature and title of certifier	Tink	- MI)	29c. Licen		500			d (Month, E		
		> Theilend			•		- 25	000		June	5,	2010	
		30. Name and address of person w	ho completed caus	se of death (item	23a) (Type, P	rint)	SPITI	AL OF	RAI	TIM	ORE		
Stat	e	31. Date filed (Month, Day, Year)	32. R	er strar's Signat	ture	110	3, 1//	AL OF	ショレ	1119			
Registra		IIIN O	8 2010	Zenewa	1. 1	parket							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

10-04148	
Don Ricardo Rice	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Crivial yiand / Department or Fleatiff and Wentai Fig. 1- For State Certificate of Death Registrar		g. No. 2010	783
Physici		Decedent's Name (First, Middle,Last)	Date of Deal Month		3. Time of Death
edical Exam	ıner	Don Ricardo Rice	May 31, 2	010	1048 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1400 Block of Gleneagle Road Baltimore	1	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.	8 Date of Bir	NA th(MM/DD/YYYY) 9. Birl	holace (State or
Director		Unknown 1 X M 2 F 59 Yrs. Wonths Days Hours Min. Usual Residence of Decedent	_	Foreig	
any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ith the Maryland 23a or 28a-f show notified at once.	or	MD NA Baltimore			1 Yes 2 No
Maryl 28a-1	Director	10e. Street and Number 10f. Zip Code	11	og. Citizen of What Cour	ntry?
th the 23a or 20tifie		2803 East Chase Street 21213		USA	
3, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leand and Mental Higene, in the James and Mental Higene, it is marked other than "natural", or items 23a or 28a-f shot rammatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc. A f	can Indian, Black, rican
after c al", on iner m	by F	3 Wildowed 4 Divorced If Yes, Give Year or Dates:		Specify: Am e	rican
, MD 21215-0036 cald should be filed within 72 hours after cald and Mental Hygiene. tem 27 is marked other than "natural", tray 27 is marked other than "natural", traymatic event, the Medical Examiner	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired to the property of the control of the property of the prop		16b. Kind of Business/I	ndustry
hin 72 e. than than	Completed			1.0	, ,
5-00 led wit tygien other the Mo	Con	12th Grade 2 Self-employed 17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, N	self-e Maiden Surname)	mployed
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be	James Rice Delor	es Mor	se	
D 27 should and Mel	To	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R	Rural Route Num	ber, City or Town, State	
MD and 2 sho salth and 2 seem 27 is		Jessica Rice-Coward-Daughter 2803 E. Chase 3 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	<u>Street</u>	Balt. Me	d. 21213
Baltimore, permit. Pages 1 ar Department of Hea important: If iten		1 X Burial 2 Cremation 3 Removal from State crematory or other place)			
Itimo it. Pag. rtment rtant: y or ot		4 Donation 5 Other Specify: King Mem. Park Cem. 6/4 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 17	4/2010	Randalls	town, Md.
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is m injury or other traumatic.		638 N. Gilmor St	lie Fu	neral Home	e P.A. . MD 2121
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	r respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a Gunshot wound to the head			Death
		or condition resulting in death) Due to (or as a consequence of):			
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			
	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	alE	d			
60, ate be ex hysician e burial	edical	UNPENDED AMENDED			
876 rtificat ing ph as the	Σ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ncy	23d. Date of delivery Month D	ay Year
Box 687 e death certific the attending p	/sician/	4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
D. B. t the de by the	P.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to	he cause of death?
ires that the signed by	d by		1 Yes	2 No 3 Prob	ably 4 Unknown
ords, w requir s been s should t	olete		24a. Was a		opsy findings available ompletion of cause of
Reco The law cate has	Completed		perfor		s 2 No
tal Rection: The	Be	25. Was case referred to medical examiner? Hospital: 1 Innation: 2 FP/Outpatient 2 DOA Other Number			
f Vi Physic er this ral dir	2	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Outlet 4 Nursing		Residence 6 Other	Scene
Division of Vital Records, tal or Attending Physician: The law requirers after death. "In Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	1 Natural 5 Pending FOUND: FOUND: FOUND: 1 Yes 2 No	Subject shot	, ,	
Visic or Atte firer des Directo	fica	2 Accident Investigation 3 Suicide 6 Could not be May 31, 2010 1037 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc.		treet and Number or Ru	ral Route Number, City
DIV Hospital or 24 hours afte Funeral Dir tely filled in	Serti	- data-	or Town, Si 1400 Block of	ate) Gleneagle Road , Ba	ltimore , MD
	ga	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at			
To the within 7 To the complet	Medi	29b. Signature and title of certifier 29c. License number	title tille, date a	29d. Date signed (Mor	
	-	O.C.M.E.		June 1, 2010	, Day, rear/
11./		30. Name and address of person who completed cause of death (Item 23a)		, -2	-
i-/ v		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201		
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006 UUME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. dent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:50 PM 06 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 199 Diana Drive Pasadena Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign WeSt^{untr}Virginia 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 1 🗆 M 2 🔽 Months Days Hours April Dy 8 and 1939 Director 216-34-5926 71 Usual Residence of Decedent show of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director E1kridge 1 Yes 2 X No Maryland Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6233 Sand Rise Court Apt 001 21075 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked Atheritan 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give
Year or Dates. Black, White, etc. 9 1 Never Married 2 Married 1 Yes 2 V No Specify. 3 Widowed 4 X Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Thomas Edward Zepp Pearl Susan Butt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael T. Nord/ Son 199 Diana Drive, Pasadena Maryland, 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 💢 Cremation 3 🗀 Removal from State AtTantic Crematory 6/8/2010 Glen Burnie, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington Blvd.,Elkridge,Maryland,21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between
Onset and Death
Months Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for Month Day Year Pregnant at time of death 5 Other (specify) g Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2 1 1 Yes 2 No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital 2 **120**00 Other: မှု 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Menth, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 6:32 PM MARTIN ROTH المالا 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Town, or Location of Death N/A BALTIMOR PITTAL 05 Baltomore (If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Numbe Birthplace (State or Foreign Country) **Funeral** 1 X M 2 🗆 F 212-26-8764 80 b8*1*/307/1929 Director NY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f s ler must be notified MD N/A BALTIMORE XX Yes 2 No Baltimore, Maryland 21215-0036 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6606 PARK HEIGHTS AVE., PENTHOUSE H 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc þ 1 Never Married 2XX Married permit. Page 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinany injury or other traumatic event, the Medical Examinany. 1 Yes 2XXNo Specify Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) REAL ESTATE INVESTOR REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, FRFD ROTH CELIA BRAND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type, Print) DOROTHY ROTH/WIFE 6606 PARK HEIGHTS AVE., PENTHOUSE H BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BETH TFILOH CEMETERY \$6/06/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Signature of Funeral Servic Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician. disease or condition hours Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Lines Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Por in the past 12 months? Day Month Year Tyes 2 □ No detached 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 Yes 2 No certificate Division of Vital 25. Was case referred to me or Attending Physician: funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: ١٥ Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manne of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death. **To the Funeral Director**: Al completed filled in by the fu 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier Date signed (Month, Day, Year) ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

	1 = For State Registrar				Pertificate of		Re	eg. No.	17834	
Physician /Medical	1. Decedent's Name (FLORINE	(First, Middle, Lasi	1)		ROSENBERO	G	2. Date of Deat Month JUNE	Day Year 04 2010		
Examiner	4a. Facility Name (If n		,		4b. City, Town, o	or Location of Death	4c. County of Death BALTIMORE			
Funeral	5. Social Security Num 215-42-10	mber 6. Se		(In yrs. last birth			8. Date of Birth (Month, Day, 02/25/	Year) 9. Bi	rthplace (State or Foreign	
Director	Usual Residence of D	Decedent		07			02/25/	1943	MD	
Marylar f show		10b. County		10c. City, Town					10d. Inside City Limits 1 Yes 2 No	
vith the Mar or 28a-f sl be notified	10e. Street and Numb			DALII	10f. Zip Code		1	0g. Citizen of What C	country?	
eath wi		INER DRIV	E, #F 12. Was Decedent B	iver in H.S.	21209	dianania Origin2 (Sa	poits Voc or No	USA 14. Race - Am	erican Indian	
15-0036 172 hours after death with the Maryland 172 hours after death with the Maryland "natural", or Items 23a or 28a-f show adical Examiner must be notified at leted by Funeral Director	3 ☐ Widowed 4		Armed Forces? 1 Yes 2 X N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🛣 No		Rican, etc.)	Black, Wh		
215-0036 hin 72 hours af an "natural", or Medical Exam	1 (Specify	15. Decedent's Ed	ucation de completed)	16a. I	Decedent's Usual Occup Give kind of work done life. DO NOT use retire	pation during most of work	ing	16b. Kind of Busines		
21215-01 ed within 72 hor ygiene. ier than "natur. t, the Medical E	Elementary/Second	dary (0-12)	College (1-4or 5 5-	+)	SOCIAL			STATE OF	MARYLAND	
thd ind ind ind ind ind ind ind ind ind in	17. Father's Name (F	First, Middle, Last)		200		18. Mother's Name		Maiden Surname)		
Maryland d 2 should be file th and Mental Hy 7 is marked oth traumatic event To Be (FRANK 19a. Informant's Nam	ne/Relationship (7	ype. Print)		ENBERG Mailing Address (Street	SHIRLEY t and Number or Rui			LGOFF Zip Code)	
- c = N L		OSENBERG	/ BROTHER	2	2700 JENNEF	R DRIVE, #	F, BALT	IMORE, MD	21209	
O gçrb			Removal from State	cemetery	Disposition (Name of crematory or other pla TFILOH CON	ace)		20c. Location - City of		
Baltim permit. Par Departmen Important: any injury	21. Signature of Fund		,	DLIII	22. Name and Addre		. ,	WOODL/ SON & BROS	AWN, MD ., INC.	
m egere	May 23a Part I Enter the	4 La	alications that caused	the death. Do no	8900 REIST	TERSTOWN F	ROAD, PI	KESVILLE,		
Physician	shock, or heart Immediate Cause (Fi disease or condition	inal	one cause on each lin		ot enter the mode of dyi	217-5001 as cardiac		esi,	Interval Between Onset and Death	
/Medical Examiner	resulting in death)		Due to (or as	a consequence of):	0.0				
<u> </u>	Sequentially list cond in any, leading to min cause. Enter Underly	ditions,	Trains B. Alice me.	Pertu	No.			_		
760, be executed sician and burial-transit	Cause (Disease or in that initiated events resulting in death) La	ijury	c. Due to (or as	a consequence of	mellip	ns type	u II			
5 8 8 5	The first teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The first teaching to immediate cause. The first teaching t									
				-						
DIVISION OF VITAI HECONDS, P.O. BOX 68 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certific te has been signed by the attending pl completely filled in by the funeral director, lage 2 should be detached for use as a Medical Certification: To Be Completed by Physician/Med	23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	3b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown							elivery Day Year	
IS, P					the underlying cause gi	ven in Part I.			ute to the cause of death?	
Hecords, he law requires the law requires to the law requires to the law requires to the law requires to the law required by	1200	gheron	voscr vidism.	200	gizzor				Probably 4 Unknown	
Vital Hecords, slclan: The law requires to certific te has been signed rector, age 2 should be Be Completed by	1,4/1	La I Walk	0 (913 .001				24a. Was a autops perform	sy prior t		
VITAI	25. Was case referre examiner?	-	Hospital:		10:	26. Place of Deat	th (Check only on	ne)		
g Phys g Phys er this eral dir	07.14	10	1 ∐ Inpatie 28a. Date of Inju	ry 28b. Ti	me of 28c. Inju			ence 6 Other (Spoots) ow injury occurred	pecify)	
DIVISION OF I or Attending Phy after death. Director: After this I in by the funeral d ertification: Tc	1 ☑Natural 2 ☐ Accident	5 ☐ Pending investigation			M 1]Yes 2 □ No				
DIVISION C DIVISION C Ital or Attending P Ital or Attending P Ital or Attent Ital Director: After t Ital or by the funera Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num. City or Town, State)							treet and Number or n, State)	Rural Route Number,	
To the Hospital of within 24 hours at To the Funeral D completely filled i		Certifying Phr	ysteian: To the best niner: On the basis of and manner sta	f examination and	death occurred at the t /or investigation, in my	time, date and place opinion, death occu	, and due to the c rred at the time, c	cause(s) and manner date and place, and d	as stated. ue to the cause(s)	
To ti withi To ti com	29b. Signature and ti	itle of certifier	m	-		se number	2	29d. Date signed (Mo		
	30. Name and the	ss of person who	completed cause of d	eath (Item 23a) (7	ype, Print)	TOWS	an W	9 311	55	
State Registrar	31. Date filed (Month	JUN 08	2010 Ser	ar's Signature	fall					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Dav Year MARY ROSTKOWSKI 07:50 AM 2010 UNE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs
Months Oays Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 🖺 F April , Day 927 Maryland 216-20-2483 83 Director Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore City Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be tural", or items 23a c Funeral U.S.A. 809 South Streeper Street 21224 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 'natural", Specify: White 3X Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Home Maker Own Home permit, Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank Gryzchowiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Putzulo (Daughter) 809 S. Streeper St. Baltimore, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State June ate cemetery, crematory or other pla St. Stanislaus 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State 10, 2010 Baltimore, Maryland Cemi 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA Signature of Funeral Service Licenses Milen 201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) VEARS CONGESTIVE HEART FAILURE Medical Examiner VEMPS PULMONARY HYPERTENSION Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of): by the attending physician and stached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed MITPAL REGURGITATION YEARS that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical TRICUSPID REGURGI TATION Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2: performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital 2 🗹 No Other: 1 🗌 Yes Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t
completed filled in by the funera 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

MEUSSA MORGAN

merissa o margarno

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MORO

29c. License number

RES-000

AVENUE BALTIMORE MD

29d. Date signed (Month, Day, Year)

JUNE 06, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0655 AM JUNE 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland General Hospita altimore 6. Sex Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 673 1 □ M 2 🗹 Months Hours Min. (Month, Day, Yea Country Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Director MD 1 Yes 2 No more 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral items ; 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married than "natural", or 1 ☐ Yes 2 M No Specify: If Yes, Give Year or Dates Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed witi ment of Health and Mental Hygier ant: If item 27 is marked other t Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ emo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trat Blvol. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Naurial 2 Cremation 3 Removal from State cemetery, crematory or other place) BaltyMD2 4 Donation 5 Other (Specify) 22. Name and Address of Facility The Derrick C. Jones Funeral Home 4611 Park Heights ave Baltimore, MD 21215 P.A. 21. Signature of Funeral Serial 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ neumonia disease or condition Medical resulting in death) **Examiner** bronic Obstructive Pulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Discerse physician and the burial-transit Failure Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autonsy 2 🗌 No 2 No 1 Yes Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Critifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 865 SHUC 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Balt md 2/20 Br 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last), 2. Date of Death 3. Time of Death Physician/ Month 39 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death COMMUNI MORE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 **M** M 2 □ F 227-26-803 Hours Min. Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Funeral Director timore 1 MYes 2 ☐ No 10e. Street and Numbe 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NO**▼** use retired) (Specify only highest grade completed) conday (0-12) College (1-4 or 5+) Be City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or To 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter Approximate Interval Between Immediate Cause (Final CANCER Physician disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No n signed by the a 9 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☐ No 3 ☐ Probably 4 💢 Unknown 1 🗌 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe within 24 hours after death.

To the Funeral Director; After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 🗀 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination almost investigation, with place and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Sho 024648 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 OCH RAVEN B 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 08 2010 Registrar

DHMH 17 Rev 7/2009

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print) RITCHIE

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5/9/2010 James Benjamin Simmons, Jr. 20:56 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Min. 1 X M 2 □ F Hours Country) 412-05-8434 91 Director TN Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director iral", or items 23a or 28a-f s Examiner must be notified N/A Washington XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 907 Euclid Street Northwest 20001 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 3 ₩ Widowed 4 □ Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event the 11-Elementary/Seconday (0-12) College (1-4 or 5+) Private Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Benjamin Simmons, SR. Pattie Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene M. Johnson/nephew 361 17th ST #2309 Atlanta, GA 30363 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Cemetery 6/4/2010 Landover, MD . Signature of Funera Service Licensee 22. Name and Address of Facility Bianchi 814 Upshur ST NW Washington, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Cardiac Arrest Physician/ Medical resulting in death) Due to (or as a consequence of Examiner Cardiomyopathy Sequentially list conditions, Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed and burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 \(\subseteq \text{Live Birth} \) 2 \(\subseteq \text{Fetal death} \) 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Pregnant a Year 5 Other (specify) Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Pulmonary Disease Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown page 2 should Renal Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? After this certificate 1 Yes 2 No Yes 2x No or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 24 hours after death Funeral Director; A Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Fune completed fi The deficial Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Machais Aubby MD62562 May 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Madhais Huffy 9901 Medical Center Drive Rockville, MD 20850

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

11IN 08

P.O. Box 68760, Division of Vital Records, After this

3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** 1:00 M Sanders /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Charlestown Care Center Catonsville | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth (Month, Day, National 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🗓 F Canada 96 Director 214-22-8943 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 719 Maiden Choice Lane 21228 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed by 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary Legal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Martha Smith Arthur J. Richardson ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Pope - Daughter 5531 Gayland Rd., Arbutus, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory Glen Burnie, MD June 8,2010 4 Denation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Sign Service Licens ture of Funeral 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **hysician** Conjective disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Ye ar 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death

To the Funeral Director: /
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) 21228 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUN 08 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#5perFH, G904, 6/872010, WS
State of Maryland / Department of Health and Mental Hygiene

For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year HENRY Spencer Month **Physician** 1:30 Am M WILLIAM JUNE 2010 i /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CORRECTIONAL HAGERS TOWN, MD WASHING TON, CO. FACILITY MCTC | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | D7 / 17 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☑ M 2 □ F 64 1945 MD Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b, County rei', or items 23s or 28s-f show Examiner must be notified at 1 Yes 2 No MARYLAND WASHINGTON HAGELS TOWN Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 18800 Roxbury Rd. 21746 USA death Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?
1 XYes 2 No 11. Marital Status be filed within 72 hours after 1 Never Married 2 Married It Yes, Give Year or Dates: Vietnam 1 Yes 2 No Specify: Specify Black þ 3 Widowed 4 Divorced "naturel" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) then Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. Driver Self-Employed 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Spencer Ernestine Tucker 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2::
Department of Health at Important: If item 27 is eny injury or other trau 21212 Alysia Murray/Sister 4726 York Rd. Balto, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) June 5, Beltsville, MD Chesapeake Crem. 22. Name and Address of Facility CAFA/Stephen D.Lohrmann P.A. 21. Signature of Funeral Service Licenses 8717 Green Pastures Dr. Balto, MD 21286 no 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RUPTURE DIBLEDING ESOPHAGEBL **Physician** VARICES /Medical Due to (or as a consequence of): **Examiner** CILLATOSIS IVER HEPATOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner DISEASE LIVER ALCO HOL HEPATITIS The law requires that the death certificate be executed burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 HEPATITISC, LIVER DISEASE ALCOHOL Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ DIABETES HYPER TENSIN 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No ♪ ↑ certificate has autopsy performed? 1 Yes 2 HNo or Attending Physician: the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 Yes 2 No INITIALLY Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA Certification: To this (28b. Time of Injury 28a. Date of Injury (Month, Day Year) Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident hours after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 DO066512 CNIMELY 06/01/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Punt) Roxbury Rd. Hazer stown, MD 21740 NIMEL 18800 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4 Physician/ Month Clifford E. Schwendy June Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2010 Rockville Montgomery Shady Grove Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 7 Hours 96 Yrs 09/08/1913 Director 095-03-3462 Just Usual Residence of Decedent 10b. County 10a. State with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director MD Montgomery Gaithersburg 7 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Schwend Funeral 301 Russell Ave. #409 20877 USA within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U. Armed Forces? 1 ★ Yes 2 No If Yes, Give Year or Dates. WWII þ 1 Never Married 2 x Married 1 ☐ Yes 2 ☑ No Specify. Specify:White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Estimator Manufacturing permit. Page 1 and 2 should be filed Department of Health and Mental Hy, Important: If item 27 is marked othe any injury or other traumatical. Be other traumatic event, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ezra Schwendy Sophia Ortlieb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18420 Cape Jasmine Way Gaithersburg, MD 20879 Brenda Krueger, daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory | 6/8/2010 . Sign — e of uneral Service Licer 22. Name and Address of FacilityRapp Funeral & Cremation Svcs. 933 Gist Ave. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ PNEUMONIA ASPIRATION disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months? Pregnant at time of death signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≦ Completed peen s 24a. Was an has autopsy this certificate 1 Yes 2 X No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 XNo Other: မူ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) **Natural** 5 Pending injury Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide City or Town, State) To the Hospital within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basy of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29c. License r

20c. Location - City or Town, State Beltsville, MD Approximate Interval Between Onset and Death 23d. Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 29d. Date signed (Month, Day, Year) ROCKVILLE MD MOLECULAR DRIVE SUITE 206 20850

1700

NY

1 ☐ Yes 2¾X No

10d. Inside City Limits

Birthplace (State or Foreign Country)

2010

Black, White, etc

State

Registrar

10110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W.D

32. Registrar's Signature

DAVARI

SHAHRYAR

JUN 0 8 2010

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene

7843

Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Modified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

15

1	1 - State Registrar Certificate of Death Reg. No.										
	1. Decedent's Name (First, Middle, Last)				2.	Date of Death	-		3. Time of D	eath	
an	Robert Mathias Sando					June 5	, ^{Day} 2010	Year	10:50	АМ	
al er	4a. Facility Name (If not institution, give street and nur	mber)	4b. City, Town, o	Location of			4c. County				
	222 Ridgeway Road		Catons	ville			Balt	imore			
		7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24		Date of Birth	()	9. Birthpl	ace (State or	Foreign	
	089-16-6169 1⊠M 2□F	89 Yrs.	Months Days	Hours	Min. Ma	month, Day,	1921	New	York		
	Usual Residence of Decedent										
	10a. State 10b. County	10c. City, Town or Lo	cation					10	d. Inside City	Limits	
ફ	MD Baltimore	Catonsvil	lle						1 ☐ Yes 2	2 No	
ie	10e. Street and Number		10f. Zip Code			10	10g. Citizen of What Country?				
<u>=</u>	222 Ridgeway Road		212	28			USA				
ner	11 Marital Status 12. Was Dece	edent Ever in U.S. 13.	Was Decedent of H	ispanic Origi	in? (Specify	Yes or No-		ce - America			
T.	1 Never Married 2 Married 1 Yes	2 X No	If Yes, specify Cuba		Puerto Rica	an, etc.)	Bla	ck, White, e נגז	tc. hite		
δ	3 A Widowed 4 □ Divorced If Yes, Giv		1∐Yes 2⊠No	Specify:			Specif	Specify: WILLE			
Be Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occup		-4	1	6b. Kind of B	usiness/Ind	ustry		
ğ	Elementary/Secondary (0-12) College (1	life	kind of work done of DO NOT use retired	dunng most d i)	or working	1					
ĕ	4	Engi	neer				Westin	ghous	e		
e e	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (F	irst, Middle, Ma	aiden Surnan	ne)			
T0 E	Mathias Sando			Jen	ınie J	Tohnson					
	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street						Code)		
	Bruce Sando So	n 101 (Dak Driv e	; Cato	nsvil	lle, MD	21228				
	20a. Method of Disposition	20b. Place of Dispo	sition (Name of matory or other place	20)	Date	2	Oc. Location	- City or To	wn, State		
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)	Crest La	wn Men.Ga	rden 6	5/12/2	2010 M	arriot	tsvil	le, MD		
	21. Signature of poneral Service Lineague	7 22	2. Name and Addre	ss of Facility	Sterl	ing As	hton S	chwab	Witzk	<u>е</u>	
		Fi	2. Name and Addre	me of	Cator	sville	, Inc.	- MD	21220		
	23a. Part 1. Enter the dise le, or complications that co		530 Edmon					e, MD	Approximate		
	shock, or heart failure. List only one cause on e	ach line.				sspiratory arres	st,		Interval Betw Onset and De	een aath	
	Immediate Cause (Final disease or condition resulting in death)	Lenic Cas	open 5/2	pall	14				ZUX	3	
	Due to (or as a consequence of):		1	,				~ ` .		
_	Immediate Cause (Final disease or condition resulting in death) a. Chemic Cardity of a My Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
ine	tany, leading to immediate cause. Enter Underlying Cause (Disease or injury										
кап	that initiated events c	or on a consequence of									
É	Due to (or as a consequence of):									
Medical Examiner	d										
Me	IF FEMALE:										
an/	in the past 12 months?		☐ Ectopic pregnanc	у				ite of delive	-	ear	
sici	1 Yes 2 No	nant at time of death 5	Other (specify)				IVI	Jitti	Day Te	di	
Completed by Physician	9 Li Unknown					00 5:				- 45- 0	
by	Part II. Other significant conditions contributing to de	eath but not resulting in the u	nderlying cause giv	en in Part I.		23e. Did toba	acco use con	-	e cause of de		
ed	hyportensin				_ 1	1 🗌 Yes	2 No	3 ☐ Prob	ably 4 ☐ Ur	ıknown	
plet	h					24a. Was an	24b.	Were autor	osy findings a	vailable	
mo					_	autopsy perform		death?	npletion of ca	use of	
e C	25. Was case referred to medical			26 Place o	of Death (C	1 Ves 2 Theck only one		1 🗆 Yes	2 LINO		
o Be	examiner? 1 Yes 2 No Hospital: 1 1	npatient 2 ER/Outpatie	nt 3 DOA Oth	or:		5 Resider		ner (Specifi	d)		
T:U	27. Manner of Death 28a. Date	of Injury 28b. Time o	f 28c. Injur	v at		. Describe hov			·/		
ij	1 ✓ Natural 5 ☐ Pending (Mont 2 ☐ Accident investigation	th, Day, Year) Injury	M 1 🗆	k? Yes 2 ∏ No	0						
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural								l Route Numb	er,		
ert	4 ☐ Homicide determined buildin	ng, etc. (Specify)				City or Town,	State)				
al C	29a. Certifier + Certifying Physician: To the	best of my knowledge, deat	h occurred at the ti	me, date and	f place, and	due to the ca	use(s) and m	anner as s	tated.		
dic	(Check only 2 Medical Examiner: On the boone) and mann	asis of examination and/or in ner stated.	ovestigation, in my o	pinion, death	n occurred	at the time, da	te and place,	and due to	the cause(s)		
Me	29b. Signature and title of certifier		29c. Licens	e number		29	d. Date signe	ed (Month, i	Day, Year)		
	1 Clarin		NY	474	13		- مري	7	2010		
	20 Name and officer	a of death (II as the	Deigh	10		<	الالالا		2-10		
	30. Name and address of person who completed caus	e of death (Item 23a) (Type,	1.70 A	10	4	110	1000	217	78		
	31. Date filed (Month, Day, Year) 32. R	egistrar's Signature	11-5/6	1 Ca	1000	1111	CVV	110	0		
te ar	1111 0 0 2010	A. Aaren									
al	JUNUO CUIU COM	1 61									

DHMH 17 Rev 1/2001

Sta Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 20ÏÖ 3:30 A M Richard Schultz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 21682 Marsh Creek Road Preston Caroline 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** sex 1 Å M 2 □ F Days Months Hours March 14,1940 Country) 212-36-1634 Director 70 MD Usual Residence of Decedent Strong the strain Hygiene.

'is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Caroline 1 Tes 2 X No Preston 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21682 Marsh Creek Road 21655 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. δ 1 XNever Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Parts Distribution General Motors Be Page 1 and 2 should be filed in ment of Health and Mental Hygant; If item 27 is marked oth Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Schultz Thomas Anna Wilepski Agnes traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Mr. Joseph Owens / Partner 21682 Marsh Creek Road Preston, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) June 8 Glen Haven Mem. Park 2010 Glen Burnie, MD 22. Name and Address of Facility 2nd Avenue SW 21. Squature of Funeral Service Licensee Glen Burnie, MD llc Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Ponset and Death Immediate Cause (Final Physician/ TYOCARD DAL CUTE disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner HERDSCLE Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examine to (or as a consequence of) burial-transi Cause (Disease or linjury that initiated events executed EN TENS DUN resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) for I in the past 12 months? Month Year Day Yes 2 No detached 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Records, 1 Tes 2 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? CARCINO MA RS certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, to 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

0 State Registrar (Check only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) 1555 are

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- State of Maryland Items 24a,25,26,27,2	Department of Loan Per dr., gr Certificate of	dealth and 1 06/08/ Death	2010akg	iene eg. No 2 ()	0 7845	
3	Physici	an	1. Decedent's Name (First, Middle, Last) Sheikh M. Saleem			2. Date of Deat Month	Day Yea	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give street and number) University of Maryland Specialty		or Location of Death	May	11 2010 4c. County of D	2:00P M	
9	Funeral Director		5. Social Security Number $065-70-6423$ 6. Sex 74 7. Age (In yrs. last 74		-	8. Date of Birth (Month, Day, 10/11/1	9. 1 935 P	Birthplace (State or Foreign Country) akistan	
	/land ow at			Town or Location				10d. Inside City Limits	
	e Mar Ba-f sh tiffied	ctor		ngton				1 □Yes 2X No	
	with the	Dire	10e. Street and Number 2737 Parallel Path	10f. Zip Code 21 009			0g. Citizen of What USA	Country?	
36	be fled within 72 hours after death with the Maryland Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 【XNo	oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W Specify: W		
Baltimore, Maryland 21215-0036	vithin 72 houne. The mature of Medical E	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of work d)	ing	16b. Kind of Busine		
2	filed v Hygie other t ent, th	Be Co	17. Father's Name (<i>First, Middle, Last</i>)	Business Man	18. Mother's Name	e (First, Middle, I	Small Bu Maiden Surname)	silless	
ylan	2 should be filed vorand Mental Hygie is marked other iranmatic event, tt	To B	Sheikh Mehtabuldin		UNK				
Mar			19a. Informant's Name/Relationship (Type. Print) Azra Saleem (Wife)	19b. Mailing Address (Street 2737 Paralle)				e, Zip Code)	
nore, l	Pages 1 and 2 nent of Health int: if Item 27 I iry or other tra			e of Disposition (Name of netery, crematory or other planington Mem.)	Park 5/12	Date 2/2010	20c. Location - City Mt. Sina		
Balti	permit. Pages Department of important; If It any injury or o		21. Signatur — Fun val Service Licensee	22. Name and Addres		N. Cou	nty Road, NY 11780	Route 25A	
7	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequent)	DSPC	ABG	or respiratory arre	est,	Approximate Interval Between Onset and Death	
j.	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of the consequen	G 1450 C 150 C 150 C	P cave Mechan	diac o	irvest Ventilat	•	
O. Box 6	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pregnance 1 □ Live birth 2 □ Fetal de 4 □ Pregnant at time of deat	eath 3 Ectopic pregnanc	çy		23d. Date of Month	23d. Date of delivery Month Day Year	
rds, P	quires that in signed by uld be deta	ρχ	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause gi	ven in Part I.		Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown		
		Completed			· · · · · · · · · · · · · · · · · · ·	24a. Was a autops perform	sy prior		
VIta V	i ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Ott	26. Place of Deat				
DIVISION OF	iling Phys 1. After this funeral di	tion: To	1 Ninpatient 2 ER	Bb. Time of Injury 28c. Injury Wo			ence 6 Other (5 ow injury occurred	Specify)	
DIVISI	al or Attend s after death. il Director: /	Certification:	3 Suicide 6 Could not be determined 28e. Place of injury - At home building, etc. (Specify)	treet and Number o	r Rural Route Number,				
	To the Hospital of within 24 hours at To the Funeral Completely filled i	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	edge, death occurred at the t n and/or investigation, in my	ime, date and place, opinion, death occu	and due to the c rred at the time, c	ause(s) and manne late and place, and	r as stated. due to the cause(s)	
	To the within 2 To the complet	Σ	PAHBOOB ASHRAF N	29c. Licen		2	9d. Date signed (M		
,			30. Name and address of person who completed cause of death (Item 23		54339		3/11/2	2010	
Ø	<u> </u>		Mahboob Ashraf 601 S. Char	les Street,	Baltim	ore, ME	21230		
	Sta Registr	_	31. Date filed (Month, Day, Year) 32. Registrar's Signatur JUN 0 8 2010	I barel					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE 2010 3, 9:28 A ROSEMARY JOAN SUMMERS Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day,) Jan. 30, 9. Birthplace (State or Foreign Country) Maryland Social Security Number **Funeral** 1 🗆 M 2 💢 Months Days Hours Min Yrs Director 212-58-3736 1950 60 Usual Residence of Decede or 28a-f show notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Abingdon ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 21009 USA 310 Logan Court death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. "natural", or þ 1 Never Married 2 X Married 2 X No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sales Distribution Order Processor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Walter William Ward Louise (nmn) Portscher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 310 Logan Court, Abingdon, Maryland, 21009 Thomas W. Summers Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 🗌 Burial 2 💢 Crei 4 Doration 5 Hilltop Service Corp: 6/7/2010 Towson, Maryland other (Specify) 21. Signature of Funer 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Pirt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest slock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Arrhythmia disease or condition resulting in death) Medical Examiner 59 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due o (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _ Live Birth 2 - Fetal death in the past 12 months? Pregnant at time of death Month Day Year signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed certificate 1 Yes 2 No Yes 2 XNo director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Tyes 2 X No Other: hours after death. neral Director: After this of filled in by the funeral dire 욘 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Hospital Medical 1. Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10 29d. Date signed (Month, Day, Year) June 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Scott Feeser M.D.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

103 Bata Blvd., Belcamp, MD 21017

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 28 2010 8:00 AM Patricia Sweeny Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Takoma Park Washington Adeventist Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** April 15, 1936 1 - M 2 - F Months Hours New York 74 Director 578**-**49**-**7470 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Hyattsville 1 ☐ Yes 2 No MD Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20783 USA 4922 LaSalle Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) animal hospital unk unk receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela Salter/niece 4011 Stoconga Drive; Beltsville, Maryland 20705 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in State cemetery, crematory or other place) 21. Signatur o Funeral Prvice Licensee Roma d S Wade 22. Name and Address of Facility State Anatomy Board; 655 W. Baltimore Street Director Maryland Baltimore. 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Interval Retween Onset and Death Immediate Cause (Final Sa 15 Sis Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner um Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Exami and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate has been sig page 2 should b 1 Yes 2 WHO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autonsy 1 Yes 2 No Yes 2 LN 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 1100 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending iniury work?
1 Yes 2 No s after death.

I Director: Af 2 Accident Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number D0060 L00

Registrar

DHMH 17 Rev 7/2009

State

MAHMINA

Cilver I prog

Aum En

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 2 701. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JUNE MORTON SARUBIN OS 2010 12:55P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death KESWICK MULTICARE BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpia Country) MD **Funeral** 1 X M 2 □ F Months Days Hours Min 0272771925 216-16-9854 **Director** 85 Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11 SLADE AVENUE, #306 21208 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) ESTATE DEVELOPER REAL ESTATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ္ပ SARUBIN LOUIS FLORA KOVENS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PHYLLIS SARUBIN / WIFE SLADE AVENUE, #306, PIKESVILLE, MD 21208 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW 06/07/2010 REISTERSTOWN, MD e of Funeral Service Lic 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury monary disease the Hospital or Attending Physician: The law requires that the death certificate be executed enero attending physician and for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 V Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No 1 Yes 25. Was case referred medica Be 26. Place of Death (Check only one) examiner? Other: 2 No ٥ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director; After this funeral 28a. Date of injury (Month, Day, Year) 27. Maryler of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funeral Direct
completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Centifying Nurse Practioner: To the best only knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D0064788 M 6 2010 on who completed cause of death (Item 23a) (Type, Print) 30. Name and address of N. EUTAWST. SUITE 301 BALTIMORE, MD 2120 821 31. Date filed (Month, Day, Year, 32. Redistrar's Signature State 08 JUN

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Thomas Seay Scanland 9:40 2010 PM June Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 635 Burkley Ave Harford Aberdeen . Social Security Number Sex 14 M 2 D F If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 444-05-2998 91 8/11/1918 Director Alabama Usual Residence of Decedent show 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 □ No |Maryland| Harford Aberdeen 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 635 Burkley Ave 21001 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Mechanical Engineer Civil Service 1 and 2 should be filed w of Health and Mental Hygi fitem 27 is marked other Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 2 Granville Scanland Lillian Duke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Scanland / Wife 635 Burkley Ave, Aberdeen, MD 21001 other i 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or otl Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Baker Cemetery 6/5/2010 Aberdeen, MD 22 Name and Address of Facility Tarring-Cargo Funeral Home, P. 333 S. Parke ST, Aberdeen, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, Parkinsons Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last Dementia the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Coronary Artery Disease Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Unknown Month signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 1 Tes 2 **X** No 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) after death. Director: After this 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 🗆 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D46412 June 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sup Sim 251 Lewis Lane, Havre de Grace, MD 21078 31. Date filed (Month, Day, Year) 32. Register's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 70/M Medical Examiner 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death N/A Social Security Number 8. Date of Birth (Month, Pay, Nov 24, Birthplace (State or Foreign Country)
Texas **Funeral** If Under 24 Hrs. 1 🕅 M 2 🗆 F Hours Min 454-94-3527 **Director** Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Glen Burnie 1 Yes 2 TNo Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 227 Margate Lane 21060 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 X No 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Robert Tapley Edith Belvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 2400 Powderhorn Way Gambrills, <u>Adrian Tapley, Son</u> Maryland 21054 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 06/07/10 Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor ^{22. Name and Address of Facility} Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to or as a consequence of PUMONI attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 4 ☐ Pregnant 9 ☐ Unknown ed by the a 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig ; page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No ပ 1 Nonpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident Investigation 1 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 In medical Examiner: To the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature ad title of certifie 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 32. R O NUL Registrar

68760

Box

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5-24-2010 Gregory Eugene Thomas 10:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver SPring Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year, 10-5-1949 9. Birthplace (State or Foreign Country) **Funeral** Min. Months 1 ★ M 2 □ F 579-66-3701 60 Director Usual Residence of Decedent 28a-f shov 10b. County 10a, State 10c. City, Town or Location be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director DC N/A Washington Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 533 47th Street Northeast 20019 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1.XXYes 2 □ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. Specify: Black Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Government Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Principal Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arthur D. Thomas Evelyn L. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret R. Thomas/Wife 533 47th ST NE Washington, DC 20019 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 12010 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery (4) Signature of Funeral Set 22. Name and Address of Facility Bianchi 814 Upshur ST NW Wash., DC 20011 23a. Part 1. Enter the disea shock, or heart failure e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final nysician/ Metastatic Uroepithelial Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Unknown Day signed by the a d be detached f 2 No g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X☐ Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy certificate 1 ☐ Yes 2 ☐ No Yes ieral Director; After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 **X** No Other: ျ 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie atd Jayanti 29d. Date signed (Month, Day, Year) 10 0052586 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silver Spring, MD 20910 Jayanti Patel 1500 Forest Glen ROad 31. Date filed (Month, Day, egistrar's Signatul State 0 8 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Year Physician CHH AM la Domer June 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day Year)
June 29, Social Security Number 6. Sex **Funeral** Hours Country 1 □ M 2 □X Months Days 82 Yrs. ,1927 Director 220-20-3338 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Evandre must be notified at 1 ☐ Yes 2 ☐ No MD n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with ll W. 20th St. Apt.2L 21218 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 □ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) llth Housekeeper <u>Private Home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 Is marked oth any injury or other traumatic event Be Unknown Ruth Edmonds ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aaron Toomer (son) 1519 N. Bond St. Baltimore, Md. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crem. June 10,2010 Balto, Md. 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 21. Signature of uneral Source Licens e Preston St. Baltimore, Md. 21213 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myo cardia hour /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to jor as a consequence of): law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate has 2 □ No 1∐Yes 2. Wi√No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division of Vital Records, P.O. Box 68760, 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certifica within 24

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 046389 2010 30. Navaand address of person who completed wase of death (Item 23a) (Type, Print) Baltimore, MD 21202 301 St Paul 32. Registrar's S'anature 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 4 9:05 PM 2010 Linda Ann Thaniel Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Baltimore Towson Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Month Day Yea 57 New York Director 1952 059.44. 5582 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at 10a. State 10b. County the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Volusia Deland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must by Funeral 2045 3rd Ave. 32724 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married þ Yes 2 No 1 No Specify: Puerto Rican Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: 3 Divorced Hispanic Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Service Representative Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Gonzalez Fuentez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thaniel /Husband Alonzo 2045 3rd Ave. Deland, FL 32724 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Jun 0! cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 4 Donation 5 Other (Specify) 2010 Signature of Funeral Service Licenses 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final 12 Marst concer MARC Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burlal-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Day signed by the at Id be detached for Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed Yes 2 death? certificate Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: ျ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specifical within 24 hours after death. To the Funeral Director: After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat 29c. License number and title of certifier

State Registrar dress of person who completed cause of death (Item 23a) (Type, Print)

32. Registra

Æ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June ^{Day}2010 Edward L. Tewey 2:35 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Towson Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Feb. 16, 1 ☑ M 2 🗆 F Director 1922 Maryland 216-16-1897 88 Usual Residence of Decedent 28a-f shov 10a. State 10b County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2X No MD Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5116 Stone Shop Circle 21117 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 X Yes 2 No Black, White, etc. <u>۾</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Commercial Tire Salesman Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Joseph Tewey Catherine Noon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Emma Tewey 5116 Stone Shop Circle; Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place. Garrison Forest VA Cem. 6/8/2010 Owings Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signature of Juneral Service Lice 1630 Edmondson Avenue: Catonsville 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. onset and Death Immediate Cause (Final Physician/ to (or sa consequence of): disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗆 No Yes 1 Yes Be (**Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death

1. Natural

2 Accident

3 Suicide 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined within 24 hours a Medical 29a. Certifier 🗆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Notes Praction or To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Sig re and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of perso 6701 57. BALTIMOLE MA 21204 WOW

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3^{Day} Physician/ Month 2010 3:47 Ам Blanche K. Taylor Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 🗆 M 2 🗆 F April 26, Year 1917 Maryland 93 Director 212-18-2013 Yrs Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If firem 27 is marked other than "natural", or the marked other than "natural". 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Ves 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 USA 6116 Bel Air Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Specify: black 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) public health Elementary/Seconday (0-12) College (1-4 or 5+) hospital medical aide Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Frederick D. Keene Jessie Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette Keene/niece 7159 McClean Boulevard; Parkville, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 X Donation 5 ☐ Other (Specify) Signature Tuneral State Anatomy Board; 655 W. Baltimore Street Baltimore, Maryland 21201 25a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ disease or condition ove Medical resulting in death) or as a consequence of Examiner Securifically list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed? Yes 2 No 2 🗌 No 1 \sum Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) N € 5 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director; After filled in by the funer 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after within 24 hours a To the Funeral C Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature nd title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

ES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Month 49 AM 4a. Facility Name (if not institution, give street and number) 2010 Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NOVYLWCS lamore 1400 odallsh 8. Date of Birth Age (In yrs. last birthday If Unde If Under 24 Hrs Min. **Funeral** Apr 22 1 🗆 M 2 🗶 F Months Days Hours Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō Funeral 23a 21207 items Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ō ð 1 Never Married 2 Married ☐ Yes 2 ☐ No 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give is marked other than "natural", Completed 3 Widowed 4 Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b Kind of Business Industry (Specify only highest grade completed) life. DO NOT use retired) /Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Be 17. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname, ပ 19a. Informant's N. me/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Department of Health an Important; If item 27 is n 33 Khonda 21229 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Himore 21. Signature of Funeral Service Lice 22, Name and Address of Eac Vaughn 151 Baltmore Fune Services National 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Due to (or as a conse tuence of a Medical Examiner months Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Metastatic In my that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Box 68760 use as yes, outcome of pregnancy

Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy atten for u in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnods peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 🏖 No 24a. Was an cate has l certificate Yes 25. Was case referred to medical examiner? **Division of Vital** funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 Minpatient 2 ER/Outpatient 3 DOA ဂ္ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined

within 24 hours after death.

To the Funeral Director: After tompleted filled in by the funera Medical 🗡 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) DUDS 163 30. Name and address ompleted cause of death (Item 23a) (Type, Print) 010 31. Date filed (Month, Day, 32. Registrar's Signature State 2010 08 Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0°6 -Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mi 1+ Pavettealt attonsvi MW 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Pirthplace (State or Foreign Months Min. 1 🗙 M 2 🗆 F Hours 83 Director 257-22-45 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Examiner must be notified at 10d. Inside City Limits Director 1 X Yes 2 No ti more 10e. Street and Numbe 10a. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 Married Maryland 21215-0036 1 🗌 Yes 2 🕱 No 3 Divorced 4 Divorced Completed Iack Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) /Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ 19h Mailing Addr ess (Street and Number or Rural Route Number, City or Town, State, Zip Code) 458 imore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State injury or 6-15-2010 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying has been signed by the attending physician and je 2 should be detached for use as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical vision of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician; The law requires Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No certificate 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of injury 28c. Injury at (Month, Day, Year) 1. Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Defining hystotian to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 3350 WILKENS VAINOO W MU 4 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Mams Honth **Physician** 4AM M 20 2010 line /Medical 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner .0 are nob 50171N $\mathcal{C}\mathcal{T}$ If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex B. Date of Birth Month, Day, **Funeral** 1□M 2**X**F Months Days Hours Min. Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show traumatic event, the Medical Examinar must be notified at MD Baltimore 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ U5A 23a Funeral items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify þ 3 Widowed 4 ☐ Divorced 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than "na any injury or other traumatic event, II a Mexicone. College (1-4or 5+) Be 2 ames Town, State, Zip Code) 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) rounsville 23a. Part 1. Enter title disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause we each line. Approximate Interval Between Onset and Death Immediate Cause (Final discase ardio Vescalar **Physician** disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, aftending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>\$</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate 1 ☐Yes 2 No Division of Vital After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. 29b. Signature and title of certifier KOKERM Dolphin Street, Balto In 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TUK NACEM 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUN 08 2010 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Williams David Mark June 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital Baltimore City 8. Date of Birth (Month, Day, Year) 2/17/1971 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1 XM 2 □ F Days Hours 218-06-9959 39 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan 28a-f shov Examiner must be notified at Director 1 Yes XXNo Maryland Frederick Frederick 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a or 5480 Prince William Court 21703 Funeral United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 ☐ Never Married 2 XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. þ Specify: 3 Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 6b. Kind of Business/Industry the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other than and Mental Hygiene. HVAC **TEchnician** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked David Willard Williams မ Dianna Lynn Yingling 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danielle N. Williams/Wife : If item 27 is or other tra 5480 Prince William Court,Frederick,Maryland 21703 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Pages
Department of I
Important: If ite
any injury or of Marriottsville,Maryland Crestlawn Mem.Park 6/8/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 21. Signature of Funeral Service Licensee 7250 Washington Blvd., Elkridge, Md. 21075 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Obstruction disease or condition resulting in death) /Medical **Examiner** Se pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 27 INC 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 Inpatient Other: 4 \sum Nursing Home ည 1 🗌 Yes 2 No 2 ER/Outpatient 3 DOA 6 Other (Specify) 5 Residence 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Director: After 5 Pending investigation Injury 1 🗌 Yes 2 No 3 🗌 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 - Homicide 24 hours a Funeral L Hospital 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the I

complete 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

13

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Margaret T. Weatherford ₩66/2010 6:15 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Magnolia Center Lanham Prince George's Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 😿 F Months Days Hours Min *~6730/1*916 **Director** |579-10-5424 93 Washington DC Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No MD Silver Spring Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 8505 Springvale Rd. Apt.A213 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar If Yes, Give Completed 3 ₩ Widowed 4 □ Divorced Year or Dates Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Church Secretary Clerical/Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eleanor Elizabeth Thomas John Truman Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Weatherford- Son 7650 Mandan Rd. Greenbelt MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 6/8/2010 Chesapeake Crematory Beltsville MD 4 Donation 5 Other (Specify) 20910 . Signature of Funeral Service Lice 22. Name and Address of Facility 933 Gist Ave. M00382 Silver Spring MD lit toluman Rapp Funeral & Cremation 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of) Examiner Cerebrovasuclar Accident Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and d be detached for use as the burlal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Dementia 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Osteoperosis page 2 autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☐ No မှု 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours 8 Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 3 [only one 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year)

State Registrar 14300 Gallant Fox Lane

But

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Regis rar's Signature

Dpinder Singh M.D.

D45660

#124, Bowie, MD

June 7, 2010

20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	-	For State		State of M	larylan		artment of <i>tificate of</i>		and N	/lental Hy		4 U I I)	17862
		Registrar 1. Decedent's Name	e (First, Middle, La	st)			incate of	Dealii		2. Date of De	Reg. No.			3. Time of Death
Physicia Medic		Kenneth	Alf:	red Wa	1ker					Month 06	Day 05	201	ľo	8:55A ^M
Examin				e street and number)	_		4b. City, Town,					County of De		1 1
Funeral	Н	Fairfiel 5. Social Security N		g & Rehab.		er st birthday)	Grow If Under 1 Yea	nsvill	Le r 24 H <i>r</i> s.	8 Date of Bir	Anne A			ide L
Director		265-24-6		IXM 2□F		5 Yrs.	Months Days		Min.	(Month, Da	y, Year) -192	.5	Country	
nd now	,	Usual Residence of 10a. State	Decedent 10b. County		10c City	, Town or Loc	cation						100	d. Inside City Limits
larylar 3a-fsl ified	Director	MD	Anne A	runde1	1	Glen E							100	1 ☐ Yes 2 🕅 No
the M or 28		10e. Street and Nur					10f. Zip Code				10g. Citi	izen of What	Countr	y?
h with ns 23a nust b	Funeral	314 1st	Avenue	SW			2106	1			U.S.A.			
r deat or iten		11. Marital Status	ied 2 🗆 Married	12. Was Decedent Armed Forces?		i. 13. V	Vas Decedent of Yes, specify Cul	Hispanic Or ban, Mexica	rigin? (Spe ın, Puerto	ecify Yes or No- Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.			
s afte ral", c	ed by	3 XWidowed		1 X Yes 2 If Yes, Give Year or Dates.	No	1 ☐ Yes 2 🛣 No Specify:						Specify: White		
2 hour	plet	(Spe	15. Decedent's E		- 11	16a. Decedent's Usual Occupation (Give kind of work done during most of working						nd of Busine	ss Indu	stry
ithin 7 ene. • than	Completed	Elementary/Sec		College (1-4 or	5+)	Ìife. DO	NOT use retired Store Wo	d)		9		Ret	tail	L
iled w il Hygi other vent, t	Be	17. Father's Name (First, Middle, Last)						ner's Name	e (First, Middle,	Maiden S			
Jical Id be f Menta arked artic e	욘	Jacob	W. Wa	1ker				Bes	ssie	L.	Dedm	nan		
shour and 7 is m		19a. Informant's Na			hter		g Address (Stree						. '	de)
and 2 Health tem 2 ther t		Mrs. Mars		r Brady /	20h Pi		Auds L	ane ¦		oate		21122 cation - City	-	n Ctata
age 1 ent of nt: If if		1 🔀 Burial 2		Removal from State	CE	emetery, cren	en Mem.					en Bu		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If the Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medic al Examiner must be notified at once.		21. Signature of Fu			1010		. Name and Add			id Aveni	-		_	rnie, MD
		DU	Came	MULLIN	014		Singleto			& Crema	ation	Serv	ices	s, PA
		shock, or hea	rt failure.List only	nplications that cause one cause on each lin	d the death e.	n. Do not ente	r the mode of dy	ring, such as	s cardiac c	or respiratory ar	rest,		ŧ	Approximate nterval Between
Pnysician/ Medical		Immediate Cause (disease or condition resulting in death)		a. HAIX	whon		eumon	19					1	Onset and Death
Examiner		,		Due to (or as	a consequ	ence of):								
	iner	Sequentially list co if any, leading to in cause. Enter Unde	nmediate	b. Duy to yr as	a con equ	ence of):		5.00					\top	
cuted and transit	Examiner	Cause (Disease or that initiated event	iinjury s	c. Demy	whe								\perp	
rate be executed physician and the burial-transit	calE	resulting in death)	Last	Due to (or as	a consequ	ence oi):								
	A edical			d										-
endini	an/N	IF FEMALE: 23b. Was decedent in the past 12		23c. If yes, outcome			Ectopic pregna	псу			1 2	23d. Date of	delivery	/
death the att	Physician/M	1 Yes 2 Unknown	No	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)					Month	D	ay Year
at the	/ Ph			contributing to death I	out not resu	ulting in the u	nderlying cause	given in Part	t I.	23e. Did t	obacco u	se contribute	to the	cause of death?
uires ti n sign	ed by									1 🗆	Yes 2	7 No 3 □	Proba	bly 4 🗌 Unknown
w requires been 2 shou	plet									24a. Was		24b. Were	autops	y findings available pletion of cause of
The la	Completed									auto perfo 1 \square Yes	ormed?	death	?	No No
ician: Sertific ector,	Be	25. Was case referrence examiner?		Hospital:			To	Place of Dea	ath (Check	(only one)				
Phys r this eral dir	e: 고	1 Yes 2) 27. Manner of Deat	No h	28a. Date of inju	ıry	ER/Outpatien 28b. Time of	t 3 DOA 28c. Inji	4 3x N		me 5 Resi			ecify)	
arth. r: Afte	icat	1 🔀 Natural 2 🔲 Accident	5 Pending Investigation		ıy, Year)	injury	wo	ork? □ Yes 2 □	- 1		,			
or Atte fter de irecto	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not l determined		ury - At hor c. (Specify)	me, farm, stre	et, factory, office	9		28f. Location (l Number or I	Rural R	oute Number,
pital o		29a. Certifier 1	Cortifuing Phy	sician: To the best of	f my knowle	adao death a	soured at the tim	an data and	place an	d due to the es		d manner on	atatad	
e Hos n 24 h e Fun oleted	Medical	(Check 2	Medical Exam	niner: On the basis of e rse Practioner: To the	examination	and/or invest	igation, in my opin	nion, death o	occurred at	the time, date a	and place,	and due to th	e cause	
To the vithing to the complete complete the	~	29b. Signature and						se number				e signed (Mo		
			V//M	WD			D38958 6					6/7/10		
CX,		30. Name and addr	L 0'	completed cause of	death (Item	23a) (Type, P	n High	nu.	2111	Su l	34	Λ <i>M</i>	و ۸	1061
Stat	te	31. Date filed (Mont	h, Day, Year)	32. Redistr	ar's Signat	ure .	n mynu	Way 3	w	run !	urn	10, 1414	<u>50</u>	100)
Registra		-	HIN O.8	onini 🎉		A A	arkel	/						

-
Ö,
9/1
89
Box
m
O
σ.
ds
Ö
ec
<u> </u>
ita
-
0
<u>ō</u>
/is
Ö

			Please	Type or Prin						•	le.	
		,	For State Registrar	State of Ma	aryland		artment of I ctificate of	lealth and N Death		giene Reg. No.	0 1786	3
	Physici	20	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month		3. Time of Deat	
	/Medic		Eula Walker						6	1 20		7 ^M _
	Examin	er	4a. Facility Name (If not institution, giv		٠	. ,		r Location of Death		4c. County of		
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age		ast birthday) Yrs.	If Under 1 Year Months Days	Sedale If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Jan 6,	Bactimore Scattimore 9. Birthplace (State or For Country) Georgia		
	D		Usual Residence of Decedent		12				Jan 0,	1750	701614	
	arylan show	_	10a. State 10b. County		10c. City	, Town or Lo	cation				10d. Inside City Lin	
	B8a-f	Director	MD Baltim	ore			T			15 600 (100	1 □Yes 2X	INO
	a or	Dir	10e. Street and Number 6600 Rossville	Rouleward			10f. Zip Code 21237			10g. Citizen of Wh	lat Country?	
	ns 23	Funeral	11. Marital Status	12. Was Decedent E	Ever in U.S	3. 13. \		Hispanic Origin? (Sp	ecify Yes or No		- American Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "Adical Examination and the notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?	1 ☐Yes 2X No If Yes, Give 1 ☐Yes 2X No Specify:				Rican, etc.)		White, etc. black	
5-0	72 ho	eted	15. Decedent's Education (Specify only highest graduations)	ducation			dent's Usual Occup	oation during most of work	ina	16b. Kind of Busi	ness/Industry	
121	/ithin ne. han "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. I	DO NOT use retire	d)	9	hoo!	thcare	
io D	iled w Hygie ther t	Co	12 17. Father's Name (First, Middle, Last	0		care	giver	18 Mother's Name	e (First Middle	, Maiden Surname		
an	d be fental	o Be	Freeman Walker	,				Gladys				
ary	shoul ind M i marl	To.	19a. Informant's Name/Relationship (Type. Print)	- 1	19b. Mailir	g Address (Street	and Number or Rui	al Route Numb	er, City or Town, S	tate, Zip Code)	
Ž	and 2 salth a 27 is er tra		Kimberly Walker	daughter		706	2 Grinde	r Court;	Austell	, Georgia	a 30168	
Baltimore, Maryland	Pages 1 and the nort of He nort of He nort of He north or other north or other north		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Qther (Special		20b. Pl	ace of Dispo emetery, cren	sition (Name of natory or other pla	ce)	Date	20c. Location - C	ity or Town, State	
Balti	permit. Departn Importa any inju		21. Signatur, Funeral Service Licer Ronal d S	Waster Virg	ctor			ess of Facility tomy Boar , Marylan		W. Baltin	more Street	
			23a. Part 1 Enter the disease, or com shock or heart failure. List only	plications that caused one cause on each lin	the death	. Do not ent	er the mode of dyi	ng, such as cardiac	or respiratory a	ırrest,	Approximate Interval Between	1
i,	Physician		Immediate Cause (Final disease or condition	seos	•						Onset and Death	١
7	/Medical Examiner		resulting in death)	Due to (or as	a co n sequ	ence of):						
	LAUIIIIICI	<u>_</u>	Sequentially list conditions,	b. Phecount	1 M C							
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Ede to (or as a	a consequ	ience ory.						
90,	be executed ician and ourial-transit	Exa	that initiated events resulting in death) Last	Due to (or as	a consequ	ence of):		· · · · · · · · · · · · · · · · · · ·				
126	ficate be ex physician s the burial	ical		d								
89	ertifica ing ph e as th	Med	IF FEMALE:									
P.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal	death 3	Ectopic pregnand Other (specify)	су		23d. Date Mont	ate of delivery onth Day Year	
Division of Vital Records, P.	w requires that s been signed b should be deta	ρ	Part II. Other significant conditions	contributing to death bu	ut not resu	Iting in the u	nderlying cause giv	ven in Part I.			bute to the cause of death	
ဝ လ	s bee	Completed							24a. Was	an 24b. W	ere autopsy findings availa	able
ž	stcian: The law certificate has b irector, page 2 s	mo							auto perfo 1 □Yes	ormed?de	ior to completion of cause eath? ⊒Yes 2 □No	of
ita	nystcian: nis certifica director, p	Be C	25. Was case referred to medical examiner?					26. Place of Deat				
<u></u>	Physic this or		1 Yes 2 No	Hospital: 1 Inpatie		ER/Outpatier		4 🗀 Nursing Ho		idence 6 Other		
ב	de de	ion:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	ry v, Year)	28b. Time of Injury	Wor		28d. Describe	how injury occurred	t .	
<u>s</u>	ttenc death ctor: y the	ficat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not b		ırv - At hoı	me. farm. str	. –	lYes 2□No	28f. Location /	Street and Number	r or Rural Route Number,	
<u>≤</u>	ai or A after i Dire	Certification: To	4 ☐ Homicide determined	e 28e. Place of Injubulding, etc	. (Specify)				wn, State)	or ridial riodic rumbor,	
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	edical (29a. Certifier 1 Certifying PI (Check only one) 2 Medical Exam	nysician: To the best of miner: On the basis of and manner sta	f examinat	wledge, death tion and/or in	n occurred at the t vestigation, in my	ime, date and place, opinion, death occur	and due to the	e cause(s) and man , date and place, ar	iner as stated. and due to the cause(s)	
	To the vithing complete the com	Ĭ	29b. Signature and title of certifier		BINA		29c. Licens				(Month, Day, Year)	
	,		1 Bruh Cc	June	NO	SUYE 1)	1 06	5094		6-1-	2010	
			30. Name and address of person who	omplet d cause of d	eath (Item	23a) (Type,	Print)	-			4 2 : 2 3 2	
	- 04-	10	DR BINH NG LY 31. Date filed (Month, Day, Year)	32. Registra	ar's Signat	ure KL	in Sai	eare (VK 130	ello mo	1 21231	
	Sta Registr		HINDS	2010 12	wa .	1	backel				1 21237	
			3011 40	-HIN JAN		1. 19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ June 1, 2010 Marie Dutton Wood 6:00 P M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Rockville Nursing Home Rockville Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 - M 2 X F Months Min September 25,1933 Director 577-50-6489 76 Virginia Usual Residence of Deceden th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Montgomery Potomac 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9029 Marseille Drive 20854 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Was Decedent Armed Forces?
1 ☐ Yes 2 ☑ No 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Administrative Assistant Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emory Neal Dutton Mozelle Bennington and 2 should be Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Wood Canody/Daughter 3838 Gallows Road, Annandale, Virginia 22003 injury or other Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Park Lawn Memorial Park permit. Page 1 and Department of Hamportant: If ite any injury or ot 20c. Location - City or Town, State June ^{Date}. 1 $ot\!\!R$ Burial 2 $ot\!\!\square$ Cremation 3 $ot\!\!\square$ Removal from State 4 $ot\!\!\square$ Donation 5 $ot\!\!\square$ Other (Specify) 2010 Rockville, Maryland 22. Name and Address of Facility Robert A. Bethesda-Chvy Chase 1nc. Bethesda, Maryland 20814 21. Signature of Funeral Service Licenses Pumphrey Funeral Home/ . 7557 Wisconsin Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician Onset and Death disease or condition Cancer of Lung with Metastasis Medical resulting in death) Due to (or as a consequence of): **Examiner** Respiratory Failure Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Duri to (or se a consequence of that the death certificate be executed Due to (or as a consequence of) resulting in death) Last -burialattending physician for use as the burial Physician/Medical 09289 IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant Box (23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed his certificate has b Il director, page 2 sh 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 🔀 Natural 5 Pending injury Accident
Suicide 1 Tyes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

P.0. Records, To the Hospital or Attending Physician: The law is within 24 hours after death.

To the Funeral Director. After this certificate has E completed filled in by the funeral director, page 2 s of Vital Division

State Registrar 29a. Certifier

(Check only one

29b. Signature and title of certifier

Swomm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas Joseph, M.D. 50 West Edmonston Drive, Rockville, Maryland 20852

31. Date filed (Month, Day, Year) 32. R 11 IN 08

👿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0047330

29d. Date signed (Month, Day, Year)

June 2, 2010

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perINF G904.6/22/2010 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day A^{M} June 2, 2010 8:50 Walter John Walsh, Jr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Friends Nursing Home Sandy Spring If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) Days 1 X M 2 □ F Yrs. 88 August 12, 1921 577-20-0097 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Maryland Montgomery Sandy Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17300 Quaker Lane, D-6 20860 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify. White Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Contract Analyst</u> U.S. Government 8. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florence Walter J. Walsh orance Kilpatrick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Emily T. Walsh/Wife 17300 Quaker Lane, D-6, Sandy Spring, MD 20860 20b. Place of Disposition (Name of cemetery, crematory or other place) June 6. 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 4 □ Donation 5 □ Other (Specify) 2010 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 21. Signature of Funeral Service Licens at House M. Mouse M01530300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Connective Haut Failure Due to (or as a consequence of) Rendelectic Cordieves andas Sisses Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATMW Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 - No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner Box 68760. P.0. Records, Division or Vital

certificate be executed and burial-trar attending physician the as nse for the detached certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physicia<u>n</u>

/Medical

Examiner

Funeral

Director

an "natural", or items 23a or 28a-f shov Medical Examiner must be notified at

the

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 Is marked other i any Injury or other traumatic event, <u>tr</u>

Physician /Medical Director

Funeral

þ

Completed

Be

Examiner

Physician/Medical

2

Completed

Be

2

Certification:

Medical

29a. Certifier

(Check only one)

death with the Maryland

filed within 72 hours after

Maryland 21215-0036

Baltimore,

State Registrar 29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

D39793

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1814 Prince Philip Sive Oney. Mays, MA opher 31. Date filed (Month, Day, Year) -32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND of THEM 180 & BED at time ht of Health and Mental Hygiene 1-Certificate of Death Reg. No. 3. Time of Death ecedent's Name (First, Middle, Last) 2. Date of Death Monthe 5:09 AM ers Physician 2010 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** n/a If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 06/14/ 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** 1 X M 2 - F Yrs. Maryland 40 **Director** unk Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show must be notified at Yes 2 No Director N/A Baltimore MD 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country ō items 23a 335 S. 21223 U.S.A. Funeral Payson Street Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 ō If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify þ Specify: 3 Widowed 4 Divorced Black "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) other than 10th Grade Construction Self EMployed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked (unk) Willie Weathers Georgia Mae ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2.
Department of Health as Important: If item 27 is any Injury or other trauonce. 335 S. Payson Street, Baltimore, MD 21223 Dontae Weathers(son) 20b. Place of Disposition (Name of cemetery crematory or other place)
JOSEPHERATORY
AND TEMPORATORY 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/08/10 Baltimore, MD 21. Signature of Funeral Service License Joseph H. Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD retuch 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ulmonary **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) physician ar Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) ed by the at detached t 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes Completed 2 X-No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1 TYes 2 🗌 No Yes or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 2 No 1 Anpatient 2 ER/Outpatient 3 DOA 1 Tyes 6 Other (Specify) ၉ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Natural ours after death. eral Director: Aft filled in by the fu Accident 1 🗌 Yes 2 🗆 No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

State

Medical

29a. Certifier

(check only

29b. Signature and title of certifie

24 hours a Funeral I Hospital

within 24 hound to the completely fi

Registrar

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

110 32. Registra

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

10-04184
John Warthen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Warthen		State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No.
Physicia Medical Examin		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year June 1, 2010 3. Time of Death 1637 hrs
(2)		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
239		Mercy Hospital Baltimore
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or Foreign
Director		219-30-0792 AMM 2 F 46 Yrs. May 1, 1964 CountMaryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
\$	ō	MD Baltimore Reisterstown 1 Tyes XXNo
Maryl r 28a-f	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ith the ?		10 Trighton Ct. 21136 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 113 Was Decedent of Hispapic Origin? (Specify Ves or No. 114 Book American Indian Status
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant: If them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.	Funeral	1 Never Married XX Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
after d	by Fu	1 Yes XX No 3 Widowed 4 Divorced If yes five Year or Dates: 1 Yes XX No 1 Yes XX No 1 Yes XX No 1 Yes XX No
2 hours afte "natural",	ted b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired)
336 thin 72 te. than "	plet	Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Attorney Law
5-00 ed with fygien other	Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic event, the Medica	Be	John Lawrence Warthen Barbara Lee Myers
Should Should and M	٩	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Trighton Ct. Reisterstown. MD 21136
ore, MD 21215-00 ss I and 2 should be filed win of Health and Mental Hygien If item 27 is marked other her traumatic event, the M		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27		1 Burial 2 XXcremation 3 Removal from State A1 frequators of other place)
altir mit. I partme porta	i	4 Donation Other Specify: Crematory & Chapel 6/7/10 Manchester, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A.
		11605 Reisterstown Rd. Owings mills, MD211:
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic cardiovascular disease Due to (or as a consequence of):
		Sequentially list conditions, b
	j.	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause
Si & U	Xan	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
60, the be executed hysician and eburial - transit	ledical Examiner	d. VINDENDED AMENDER 7 AMENDER 7 AMENDER 7
60, ate be a hysicia	Medi	- 23a, 27, per ME g905 7/9/10 TT
6876 certificat nding ph	an/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year
Box 687 t death certifica the attending p ed for use as th	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown
cords, P.O. Box 6876 law requires that the death certificath has been signed by the attending phe should be detached for use as the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Division of Vital Records, P.O tal or Attending Physician: The law requires that is after death. "al Director: After this certificate has been signed be in by the funeral director, page 2 should be detacted in by the funeral director, page 2.	ed by	1 Yes 2 No 3 Probably 4 ✓ Unknown
tal Records cian: The law requ certificate has been	Completed	24a. Was an autopsy findings available autopsy prior to completion of cause of
Rec The la icate h	틩	performed? death? 1
Vital Rec systeian: The his certificate director, page	Be	25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other
of Viing Physical After this	위	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 1 1 1 1 1 1 1 1
Division of 'ppital or Attending Phours after death. The Director: After tilled in by the funeral	ertification:	1 Yes 2 No
ivision or Atten after death Director:	ije	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City
Spital hours a neral l	Sel	4 Homicide determined (Specify)
		29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
To T with	Medical	and manner stated. 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		Marka () June 2, 2010
7/4	İ	30. The and address of person who cause of death (Item 23a)
9		Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201
Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signature 33. Aparks
	_	JUN VO COTO JE PROVINCE DE LA CONTRACTOR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** JUN8 010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOINS HOPKINS BAYVIEW MEDICAL CENTER TIMOR If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🖵 F Hours Min. 207-24-0267 Director 3-1-1932 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or Items 23a or 28a-f show any Injury or other traumatic event, the Marical Evannise must be mutified at any injury or other traumatic event, the Marical Evannise must be mutified at any once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No PA Indiana Co. Aultman 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 250 4th Street 15713 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🕱 No 1 ☐ Yes 2 [X]
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arley Shaffer Lillian Markel 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scheree Cardarella 7858 Charlesmont Rd. Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Creamtory 6-4-10 Baltimore, MD 22. Name and Address of Facilit Kaczorowski Funeral Home, PA 21. Signature of Fune Dundalk Avenue Baltimore, MD 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** HOUR disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, it any could go to much a cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy perform 1 ∐Yes 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 V Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Name and address of person who completed cause of death (Tem 23a) (Type, Print)

Regist

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	-	ja.	-
T-	N	0	5

		1- For State Registrar	•	Cer	rtificate of	Death		•	Re	eg. No.		
Physicia	n/	1. Decedent's Name (First, Middle						2	2. Date of Dea Month	th	ar	3. Time of Death
Medical Examin	ner	Heath '	Young					,	May 27, 2	010		1053 hrs
		4a. Facility Name (if not institution Holy Cross Hospital	n, give street and n	umber)] '	4b. City, Town,		of Death		4c. County		
			0.00	7. Age (In yrs. I		Silver Spr		0.444	lo 5 : (5)	Montgor	•	
Funeral Director		412-59-4304	6. Sex	7. Age (in yrs. i	•		ays Hour	ler 24Hrs. s Min.	8. Date of Bir	th(MM/DD/YYYY ' TOOO	9. Birt Foreig	hplace (State or n Virginia
			1 M 2 F	2.2	Yrs				May12	4,1988	Cou	untry)
, my		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Locati	on						10d. Inside City Limits
bow s		TN.		Ma	ryvil]	Le						1 Yes 2 X No
ne Maryland or 28a-f show any fred at once.	윙	10e. Street and Number				10f. Zip Code				Og. Citizen of Wi	hat Cour	
ith the Maryland 23a or 28a-f sho notified at once.	Director	1023 Young Av	70 n 110			3780	1			U.S.A.		
with t 18 23a	핕	11. Marital Status		edent Ever in U.	S. 13. Wa	s Decedent of F		gin? (Spe	cify Yes or No			
or items	Funeral	1 Never Married 2 Ma	rried Armed F	orces?		es, specify Cub					e, etc.	
after o	by F	3 Widowed 4 Divo	orced If Yes, Give Yea		1	Yes 2X	lo specify:	:		Specify:	Whi	te
nours	교[15. Decedent's Education (Spec			16a. Decedent	t's Usual Occup ost of working li	pation (Give	kind of wo	rk done	16b. Kind of Bu	siness/Ir	ndustry
16 n 72 h isan "r	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)					u)			
5-0036 led within 7/ Hygiene. other than	틹	12th 17. Father's Name (First, Middle, 1	1-0		Nig	ght St						rvice
15- filed al Hyge ed out	ğ Be	Robert You	•					rs Name (1 Caci		Maiden Surname)	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	일	19a. Informant's Name/Relationsh			19b. Mailing	Address (Str				nanan nber, City or Tow	n State	Zin Code)
AD 2 sho 1 and 27 is matic		Robert Young		.)								1.37849
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ı	20a. Method of Disposition		20b. F	Place of Disposi	tion (Name of c			Date	20c. Location -		
nor ages nt of nt: If other		1 Burial 2 Cremation		om otate	crematory or oth		Car	May	2010	Alcoa,	TN	т
litin nit. P artme fortar	ŀ	4 Donation 5 Other Species L		511								I Home, PA
Balt permit. Depart Import		THAT IN										Md.21222
Physician	T	23a. Part I. Enter the disease, or of failure. List only one cause of	complications that c	aused the death.								Approximate Interval
/Medical Examiner	1	Immediate Cause (Final disease		done an	d dilti	azam in	toxic	ation	1		77	Between Onset and Death
Adminer	-	or condition resulting in death)		consequence of								
	اءِ	Sequentially list conditions,	b.		n.							
	<u></u>	if any, leading to immediate cause. Enter Underlying Cause	C.	consequence of	}.						10	
p is	/Medical Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):							
xecuted and transit	崇	[V]	d		_							
e be exysician	ğ	X UNPENDED	23a,	27,28a-	f,per M	E g904	6/10/	10 T	Γ		-	
8760, ifficate be ug physici		IF FEMALE: 23b. Was decedent pregnant in the	256. II yes, i	butcome of pregr	laricy			c pregnanc		23d. Date of Month		ay Year
Box 68 e death certificate the attending ed for use as t	힐	past 12 months?	4 Pregn	ant at time of dea	oth	aldeath 3 er (S <i>pecify)</i>	сооріс	o programo	,	Monar	Da	ay real
Bo e deal	Physician	1 Yes 2 No 9 Unkr	9 Olikik									
P.O. B that the d		Part II. Other significant condition	ons contributing to	death but not re	sulting in the ur	nderlying cause	given in Pa	art I.				he cause of death?
S, F. uires uires a sign	9											ably 4 🗹 Unknown
ords, w requir as been a	흸								24a. Was a autops	y p	nor to co	opsy findings available ompletion of cause of
Rec The 12 Icate h	Completed								perform		leath? ✔ Yes	2 No
Vital Fysician: Sysician: director, p	8	25. Was case referred to medical examiner?	(I)itali			26.Plac	e of Death	(Check on	y one)			
Physic ruthis	<u> </u>	1 🗸 Yes 2 No		npatient 2				Nursing I		Residence 6	Other:	
n of		27. Manner of Death 1 Natural 5 Pendir		of Injury Day,Year)	28b. Time of In		ury at Work		_	ow injury occurre	∌d	
Sior Attend death ector: by the	i		igation FG 37		Fd 9:00	amj	Yes 2X		ınk			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial rirans.	Certification:	3 Suicide 6 X Could	not be	of Injury - At ho found i			building, etc	c. 28	or Town, St	ate 8 0 4 0 1	3th	al Route Number, City
lospit Hour Unnerrally fill		29a. Certifier	(Openiny)				data and -1-					
To the Ho within 24 within 24 completel	Medical	(Check only one) 2 Medical Exam		of examination an			-					
To Con	활	29b. Signature and title of certifier	and manner st	ated.		29c. Licen	se number			29d. Date signe	ed (Mont	th, Day, Year)
		Dum.				O.C	.M.E.			May 28, 20		
	ŀ	30. Name and address of person w	vho completed caus	e of death (Item:	23a)							
		Donna M. Vincenti, MD		ledical Exam	,	Penn Stree	t, Baltimo	ore, MD	21201			
Sta		31. Date filed (Month, Day, Year)	32. Re	gistrar's Signatur	е							
Registra		JUN 0 8 2	1010 Den	and d	. Low	Cast .			_			
DHMH 17 Rev 1/200 OCME 2006	1	00	ME		ORIGINAL	11-1						

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 20^{Year}0 Walter John Zdon, Sr. 2: 35PM June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Harford **Examiner** 4b. City, Town, or Location of Death Churchville 126 Hopewell Rd. 6. Sex 1 M 2 D F 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month Day, Months Days Hours Min 1940 New Jersey 70 **Director** 148-30-8750 May Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Churchville Harford MD 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21028 126 Hopewell Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Specify.White Completed 3 Widowed 4 Divorced Year or Dates Vietnam 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Dept. of Defence Artillery Tester Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Theresa Genieve Larm Michael Zdon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
126 Hopewell Rd, Churchville, MD 21028 19a. Informant's Name/Relationship (Type, Print) Madeline L. Zdon Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Chester, Date Department of Important: If it any injury or o 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place 6/10/2010 R.A. Ferris & Co 4 Donation 5 Other (Specify) Pennsylvania Signatur 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A.
333 S. Parke St, Aberdeen, MD 21 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition **Medical** resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 🕅 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

MAN 31. Date filed (Month, Day, Year)

wan

32. Registrar's Signature

ORIGINAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

2010

amore

June 7,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Robert Edward Adams, Sr. 1653 21 May Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Olney Montgomery General Hospital Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth **Funeral** Country) New York 1 🛛 M 2 🗆 F Months Days Hours Min. April Day, 093-26-2135 74 Director Usual Residence of Decedent Show or 28a-f shov notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a o Examiner must be Funeral Page 1 and 2 should be filed within 72 hours after death with 1 timent of Health and Mental Hyglene. Sassers 1 filems 27 is marked other than "natural", or items 23a lury or other traumatic event, the Medical Examiner must but or other traumatic event, the Medical Examiner must but 1 20905 U.S.A. 14604 Notley Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian. Armed Forces' Black, White, etc. Completed by 1 Never Married 2 X Married X Yes 2 No 1958-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced White 1961 th and Mental Hyglene.
27 is marked other than "natura" Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) IBM Account Executive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Elizabeth Flynn William S. Adams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14604 Notley Road, Silver Spring, Maryland 20905 Bernice T. Adams - Spouse permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Mem. Park 05/26/2010 Rockville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave.. Silver Spring, MD 20904 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) DAYJ Medical Due to (or as a consequence of): Examiner BACTERIAL PERITUMITUS SPONTANEOUS Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed LIVER CIRRHOSIS for use as the burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Year Pregnant at time of death 2 🗌 No detached 1 L Yes 2 L 9 L Unknown a Unknown Division of Vital Records, P.O. To the Hospital or Attending Physician: The law Towns and Within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACUTE RENAL FAILURE 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an HYPERKALEMIA autopsy performed death? 1 Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51 10065661

State Registrar DEBORAH

31. Date filed (Month, Day, Year) MAY 24 2010

18101 Prince Philip Drive, Olney,

Maryland 20832

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUBH

D. O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Khosrow Alizadeh May 2010 6:00 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 🙀 M 2 🗆 F Months Days Hours Min. (Month, Day, Year) Country) Director 523-89-2687 lugust 23. 1933 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Montgomery Gaithersburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 9238 English Meadow Way 20882 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, an "natural", or iter Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: Specify: White Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 at Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Chemist Education/Research Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of ပ္ Mohammad Hasan Alizadeh Talaat Alizadeh Department of Health and Important: If item 27 is n any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anoushah Shokouhi / Daughter 9238 English Meadow Way, Gathersburg, MD 20882 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park May 15, 2010 Falls Church, VA Signature of Funeral Service Licensee 22. Name and Address of Facility Kurf Bake National Funeral Home, 7482 Lee Hwy, Falls Church, Va 22042 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cardiac Arrythmia Medical Due to (or as a consequence of) Examiner Respiratory Failure Sequentially list conditions if any, leading to immediate cause. Enter Undarrying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami the attending physician and hed for use as the burial-transit Adult Respiratory Distress Syndrome Due to (or as a consequence of) resulting in death) Last Physician/Medical Aspiration Pneumonia Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 2 . No 9 Unknown been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 🙀 Unknown Coronary Artery Disease Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy page 2 2 No 1 Yes Yes 2X No **Division of Vital** funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Tes 2 X No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Phospital or Attending Pl 24 hours after death. Funeral Director: After the 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation filled in by the 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0064478 1enece -May 10, 2010

DHMH 17 Rev 7/2009

State Registrar alla

Dr. Fisehatsion Mehari, 9901 Medical Center Drive, Rockville, MD 20850

Date filed (Month, Day, Year) 101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month 2010^{ea} Margaret Allman 10. 355 Hrs.^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery Holy Cross Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign, Country WEST Africa 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months 148-96-1587 April 28,1970 Sierre Leone 40 **Director** Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 X Yes 2 No Camden Camden New Jersey 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 429 Hillside Avenue 08105 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 X Married ģ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. **Black** Specify: 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) within Physical Therapist years Medical Be be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Edmund Vincent Juliana Pratt . Page 1 and 2 should b treent of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edmund Vincent (Father) 429 Hillside Avenue; Camden, New Jersey 08105 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of h Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Pennsauken, Camden, Arlington Cemetery May 22,2010 4 Donation 5 Other (Specify) New Jersey 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Andre Sanders & Sons Mortuary Services, 13329 Woodbridge Street; Woodbridge, Va. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Septic Shock Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed ed by the attending physician and detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 **X** No 9 Unknown 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Anoxic Brain Injury Completed 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 1 ☐ Yes 2 ☐ No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 **X** No မြ 1 X Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending Accident Investigation Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the To the I only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and the 29c. License number D63579 11, 2010 May 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tayag, M.D.; 1500 Forest Glen Road; Silver Spring, Maryland 20910

DHMH 17 Rev 7/2009

State Registrar Maria J.

31. Date filed (Month, Day, Year)
MAY 24 2010

			Please Type or Pr							0	
		For State	State of M	/laryland				nd Mental Hy	giene	hin	17871
		1 - State Registrar 1. Decedent's Name (Firs	st Middle Last)		Ce.	rtificate of	Death	2. Date of De	Reg. No	GUIU	3. Time of Death
Physic /Med	ical	Anna Co	therine Bo institution, give street and number	luch		4b Oth Town		Month 05	Day	29 Year County of Deat	1040 A M
Exami Funera		5. Social Security Number	o. Mamorial	Age (In yrs. las	tal t birthday)	4b. City, Town, o	nd M	Hrs. 8. Date of Bir		S. Birt	hplace (State or Foreign
Director		Usual Residence of Deced	1 □ M 2 □ F	89	Yrs.	Months Days	Hours	Min. (Month, Da	192	\ Mar	yLand
arylan show	-	10a. State 10b.	County	10c. City,		cation					10d. Inside City Limits 1 ☐ Yes 2 🔀 No
the Ma 28a-f	Director	PA Solution Services Street and Number	Somerset	Addi	son	10f. Zip Code	10g Cit	izen of What Co			
3a or	Ö	298 Old For	-t DA			15411			USA		unity.
death	Funeral	11. Marital Status	12. Was Deceder Armed Forces	t Ever in U.S.	13.	Was Decedent of I	Hispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)		14. Race - Ame	
Datumore, Maryland 21213-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Examinar must be notified at any once.	d by Fu	1 ☐ Never Married 2 3 🗗 Widowed 4 ☐ D	2 Married 1 ☐Yes 2 If Yes Give	No	lo 1 ∐Yes 2 🖾 No Specify:				Specify: White		
"natu	letec	15. D (Specify onl)	Decedent's Education ly highest grade completed)	Į.	(Give	dent's Usual Occu kind of work done	during most o	f working	16b. Ki	ind of Business/	Industry
d Z IZI filed within Hygiene. other than ent, the Me	Completed	Elementary/Secondary	(0-12) College (1-4o		Homer	DO NOT use retire naker	na)		Ow	n Home	
and a be filed antal Hyg ced other c event, I	Be C	17. Father's Name (First, I	Middle, Last)		22011.01		18. Mother's	Name (First, Middle			
should be and Mental marked o	10	Rufus Bowse	er				Elizal	beth Gatte	rmar	ı	
Mar 12 sho th and 7 is m traum		19a. Informant's Name/Re				,		or Rural Route Numb			<u></u>
Te, IN Tand Health Tem 27	13	20a. Method of Disposition	Bowser/Sister	20b. Plac		osition (Name of matory or other pla		., Grantsv		ocation - City or	21536 Town, State
Dallillord permit. Pages 1 Department of I Important: If ite any injury or of		1 XBurial 2 ☐ Cren 4 ☐ Donation 5 ☐ C	emation 3 Removal from State Other (Specify)	e			i	. June 2,	2016	O Accid	ent. MD
callti rmit. ppartm porta y inju		21. Signature of Funeral S		130.	22	2. Name and Addre		Newman Fu			
0 89E88		1 Deger	m O flevon	w				rantsville		21536	
Physician		shock, or heart failur Immediate Cause (Final disease or condition	ease, or complications that caus ure. List only one cause on each	ed the death. line.	1	ter the mode of dyi	ing, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between Oncet and Death
/Medical Examiner		resulting in death)	Due to (or a	sasonsequer		7	1				land
ed sit	iner	Sequentially list conditions if any, leading to anneolat cause. Enter Underlying Cause (Disease or injury	ns, b. Due to (or o	is a consequer	iou of j:				0 1		
be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	С	s a consequer							
ficate be physicial the burner of the burner	ical	d									
A OC certific ding pl	/Med	IF FEMALE:	220 If you system	o of magness							
To the Hospital or Attending Physician: The law requires that the death certificate be executifing the hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transpace.	hysician/Medical	23b. Was decedent pregn in the past 12 month 1 □ Yes 2 No 9 □ Unknown	hs? 1 ∐ Live birth	2 Fetal deat time of dea	eath 3	☐ Ectopic pregnand ☐ Other (specify) _	су	23d. Date of delivery Month Day Year			
equires that een signed to ould be deta	d by P	Part II. Other significant of	conditions contributing to death	but not resulting	ng in the u	nderlying cause giv	yen in Part I.				the cause of death?
law re	Completed	CHF, pu	alm HTN. A	xieti				24a. Was		24b. Were au	stopsy findings available completion of cause of
i: The	S							perfo 1 □ Yes	rmed?	death?	
sician sicertifi rector	Be	25. Was case referred to r examiner? 1 ☐ Yes 2 🗷 No	Hospital:	tient 2 ☐ EF	VO. 4	Ott	20r:	Death (Check only o			
g Phy g Phy rer this	n:T	27. Manner of Death	28a. Date of in	jury 28	Bb. Time of Injury	II 3 LI DOA	4 LI NUIS	ing Home 5 ☐ Resi			city)
endin eath. or: Aff	atio		investigation	yay, rear)	injury		Yes 2 □ No				
al or Att safter de I Directe d in by t	Certification: To	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined 28e. Place of I building,	njury - At home etc. <i>(Specify)</i>	e, farm, str	eet, factory, office		28f. Location (City or To			ıral Route Number,
ne Hospita n 24 hours ne Funera pletely fille	edical C		Certifying Physician: To the besing Medical Examiner: On the basis and manner	of examinatio							
withi To t	Ž	29b. Signature and title of	f certifier			29c. Licens	se number		29d. Da	te signed (Mont	h, Day, Year)
		1 /had	kelf//			H0064	1705		2/	10/11	C
	4		person who completed cause of Porter, 311 N.	4-1- C+	0	-1-1 N	1D 215	50			
St	ate	31. Date filed (Month, Day	y, Year) 32. Fegis	trar's Signatur	e ,		لدے س	J.			
Regist		JUN	1 - 2 2010 And	trar's Signatur	1	aver .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MAY 16, 2010 **Physician** SARA FOARD BAUZENBERGER 1:24 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** WILLIAM HILL GARDENS EASTON TALBOT If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months Days | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2**X** F 167-38-9067 3/11/1917 93 **NEW JERSEY** Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ary or other traumatic event, the Medical Evanting must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2X No Directo MD TALBOT OXFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4357 HOLLY HARBOR ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 WHITE 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify: þ Specify: 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 OWN HOME 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MALCOLM BAYARD FOARD SARA LEEMASTER ပ္ 9a. Informant's Name/Relationship (Type. Print)
CONSTANCE I. WALLACE, DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4357 HOLLY HARBOR ROAD, OXFORD, MD 21654 altimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State Department of Important: If its any injury or o once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION 5/18/2010 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1 month Lyanition disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bleed Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed Altheimers Demention burial-tran and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No certificate 1 □ Yes 2 🗆 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1956 + 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 5 ☐ Pending investigation 1 Natural death. 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier EX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RO77623 home CRNP 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easten, MD, 2/60/ 545 Cynwood Dave RS 6 Krystal 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANICE L. BLADES Month Day Year 1953 mai Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Laster labot memorial spita If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days Hours 214-32-6080 8/27/1935 MARYLAND Director 74 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD TALBOT EASTON ò 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 124 PROSPECT AVENUE 21601 USA 12. Was Decedent Ever in U.S. Armed Forces2 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 er than "natural", or, the Medical Exan 1 ☐ Yes 2X No Specify. WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 10 KEY PUNCH OPERATOR COSMETICS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ WALT PASSWATER VIOLA CONLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra JAMES BLADES, HUSBAND 124 PROSPECT AVENUE, EASTON, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) JUNIOR ORDER CEMETERY 5/20/10 PRESTON, MD 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 10/WOTIC disease or condition 19 4 CANI Medical resulting in death) Due to (or as a consequence of). Examiner Eequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Pregnant at time of death Day Year g Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given, in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe page 2 should 24b. Were autopsy findings available prior to completion of cause of death? RIOR 24a, Was an performed certificate I 2 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 140 ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Hospital 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown completed filled in by 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) of pers LUDWIG J. EGLSEDER 503 CYNWOOD DRIVE, EASTON, MD 21601 31. Date filed (Monti istrar's Signature Registrar DHMH 17 Rev 7/2009 **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Miriam Adella Hamilton Banks 9:52 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Lanham Doctors Community Hospital 9. Birthplace (State or Foreign Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** Months 1 🗆 M 2 🕱 Days Hours March 27 93 Jamaica, Indies Director 218-69-0397 .1917 Usual Residence of Decedent shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2**X** No Maryland **Prince Georges Bowie** 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 11806 Parallel Road 20720 Jamaica, West Indies Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: "natural", 3 XWidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) **9th grade** College (1-4 or 5+) Mental Hygiene. Domestic Homemaker Be altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev one. Wright Arthur Hamilton Laura 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hermine Cecilly Robb (Daughter) 11806 Parallel Road; Bowie, Maryland 20720 20a, Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State May 28,2010 4 Donation 5 Other (Specify) George Washington Cemetery Adelphi, Maryland atur funeral Service ce 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 2001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) 0491 hours Medical Due to (or as a consequence of): **Examiner** NG 110 6406 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) 11 () To the Hospital or Attending Physician: The law requires that the death certificate be executed vertons physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Year Pregnant at time of death 5 Other (specify) Unknown the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Rennl 2 No 3 Probably 4 Unknown Completed I 1 Yes 12betes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform Yes 2 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 2 🗆 No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29c, License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registr

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ <u>Shannon Ronald Brooks</u> Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince Georges Lanham Doctors Community Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Min 1 **X**M 2 □ F 0772072946 D.C. Yrs. Director 577-62-1495 P3 Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c, City, Town or Location 10a. State death with the Maryland Director 1 XYes 2 ☐ No Lanham Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral AZU 20706 6502 97th Ave- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Patent & Trade Office Patent Examiner 75 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Edith Ayers Carlton Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>502 97th Ave., Lanham, MD 20706</u> <u>Ava Brooks / wife</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ➤ Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery | O5/2<u>5/2010| Cheltenham, MD</u> 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Se Strickland Funeral Services Allentown Rd., Camp Springs, MD 20748 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE Live Birth 2 Fetal death yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy this certificate has performed 2 🗌 No 1 Tes Yes within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death iniury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Excertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated The state of the cause of the cause of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the of certifier 0 C

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SAID A IDAEE

1. Date filed (Month, Day, Year)

MAY 2 6 2000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) $\underline{1}8^{\mathsf{Day}}$ MAY Physician/ BROWN 20°10 LUWANDER 0015A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 55 yrs. If Under 1 Year If Under 24 Hrs. 8 Date of Birth Funeral (Month, Day, Year) 1 □ M 2🛣 F WASHINGTON DO 579-72-0146 Director Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No PRINCE GEORGE'S GREENBELT 10g. Citizen of What Country?
UNITED STATES 10f. Zip Code 20770 Funeral 8447 GREENBELT RD #201 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, AtCK 1 ☐ Yes 2 X No If Yes, Give þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: 3 Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than ' Elementary/Seconday (0-12) College (1-4 or 5+) SECRETARY PRIVATE and Mental Hygiene. the it. Page 1 and 2 should be filed within thrent of Health and Mental Hygiens rate: If item 27 is marked other the njury or other traumatic event, the $1.2 \pm h$ Be 18. Mother's Name (First, Middle, COREAN MILES 17. Father's Name (First, Middle, Last) Maiden Surname) CHARLES LEE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 FLORIDA AVE NE #1003 WASH., DC 20002 COREAN LEE/MOTHER permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State QUANTICO NAT. CEM 5/26/2010 QUANTICO, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CAPITOL MORTUARY 21. Signature of Funeral Service 1425 MARYLAND AVE., NE WASH., DC 20002 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the diseas Part 1. Enter the disease, o shock, or heart failure. List pediate Cause (Final Immediate Cause (Final Physician/ 12 hour disease or condition resulting in death) andingenie Medical Due to (or as a considence of) Examiner nond Sequentially list conditions, if any, leading to in neutricourse. Enter Underlying Cause (Disease or iinjury Examine as a consuminence that the death certificate be executed attending physician and for use as the burial-transit Caron that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death ed by the a P.O. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 Tes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Impatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Division 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier CExcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar Ken in

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. Lindgran

32. Bec

MD

07966

7901 Maple

Takon Pack MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Hyman BIALEK Physician/ May 20, Day 010 Year 11:15 Am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring 5. Social Security Number 7. Age (In vrs. last birthday) if Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Min. Sept. Day 4 (ear) 1919 Country) New York Director 082-12-7949 90 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring Maryland Montgomery 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1002 Whitehall Street 20901 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 X Widowed 4 Divorced WW II Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Accounting Accountant permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other: any injury or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Lillian Ruderman Abraham Bialek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zio Code) 6912 - 23rd Place, Hyattsville, MD 20783 Judith Dulaney, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 05/21710 1 🂢 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) of Remembrance Memorial Park Clarksburg, MD 21. Signature of Fureral Sc TOPCHTHYKY HEDWew Funeral Home <u>254 Carroll</u>St., NW, Washington, DC 20012 23a. Part 1. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Éxaminer <u>Coronary Artery Disease</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and Due to (or as a consequence of) nding physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Acute Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🙀 Unknown Completed Chronic Renal Disease Stage 4 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Anemia, Hypertension 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be examiner? 1 ☐ Yes 2 X No Other: ဂ္ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death ė 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending Certificat 1 Yes 2 🗆 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one ure and title of certifier 29d. Date signed (Month, Da May 20, 2010 D 66249 2+1 nd address of person who completed cause of death (Item 23a) (Type, Print) Road, Silver Spring, MD han Duran, M.D., 1500 Forest Glen Road, Silver Spring, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

24

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per dr., g904,06708/2010dhb For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANIS 20^{Year} RHEA BLANCHARD MAY 7:40 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2250 BLANCHARD PLACE BRYANS ROAD CHARLES 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea APR . 8 , 1 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2√3/F Months Days Hours Min. OKLAHOMA Director 70 Yrs. 1940 213-38-4459 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Examiner must be notified BRYANS ROAD MD CHARLES 1 Yes 2 No ō 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2250 BLANCHARD PLACE 20616 U. S. A. "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 ☐ No Specify: Completed 3€XWidowed 4 □ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER AT HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည CHARLES BURNS DORA BAKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT PRICE/EXECUTOR 603 POST OFFICE RD.#206 WALDORF,MD 20602 MAY Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 😾 Cremation 3 🗆 Removal from State METRO CREMATORY ALEXANDRIA, VA 4 Donation 5 Other (Specify) 19,2010 21. Si vature of Funeral Service 22. Name and Address of Facility RAYMOND FUNL.SERVICE, P.A. 5635 WASHINGTON AVE., LA PLATA, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Day 1 Yes 2 9 Unknown 2 🗆 No sate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy death? 1 ☐ Yes 2 ☐ No 2 🔽 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home Residence 6 Cher (Specify) မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Patural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one)

State Registrar 29b. Signature and title of certifi

30. Name and address of pers

31. Date filed (Month, Day, Year,

tho completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month Day) 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Gibson Francis Clupp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Western Maryland Regional Medical Center Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min (Month, Day, Year) June 30, 1949 Country) Maryland Director 219-54-1435 60 Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant; If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Cumberland 1 Yes 2 No Maryland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10301 Christie Road, N.E. 21502 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Construction 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alec Gibson Frances Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Hardin - Sister 945 12th Street, Pasadena, Maryland, 21122 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of h
Important; If ite
any injury or ot Dateune 04, cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory Cumberland, Maryland 2010 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A. Brand 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Stage Renal disease or condition resulting in death) nd Medical Due to (or as a consuluence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence or, for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) ☐ Yes g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has I autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2, No Other: 1 🗌 Yes Certificate: To ER/Outpatient 3 DOA 1 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 2 🗆 No Accident Investigation 24 hours after deat Funeral Director. 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Centifying Nurse Practioner to the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29b. Signature an title of ce 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , Cumberland $\chi \chi \delta$ aman31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

JUN-2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2		7
State of Maryland / Department of Health and Mental Hygiene	10	1

		1- For State Registrar			Certificate	of Dea	ath			Re	eg. No.			
Physici		Decedent's Name (First, Midd	ile,Last)							Date of Dea	th			3. Time of Death
Medical Exami	ner	Tineal Irlean	Carter						1	Month May 12, 2	Day 010	Yea		1144 hrs
		4a. Facility Name (if not institution		number)		4b. City	, Town, or L	ocation of I	Death		40	. County o	f Death	
		5201 Wheeler Road				Oxo	on Hill				F	Prince G	eorge	's
Funeral		5. Social Security Number	6. Sex	7. Age (In	rs. last birthday)	If U	nder 1 Year	If Under 2	24Hrs. 8	B. Date of Bir	th(MM/	/DD/YYYY	9. Birti	nplace (State or
Director		579-64-8832	1 M 2 X	_	61	Yrs. Moi	nths Days	Hours	Min.	11/5/	194	8	Foreigr Cou	Washington
		Usual Residence of Decedent	1 M 2 A		01	113.		لــــــا	ш	11/5/	174			DC.
any		10a. State 10b. County		10c.	City, Town or Lo	cation								10d. Inside City Limits
<u> </u>														1 X Yes 2 No
yland f show once.	ţ	Maryland Prince	e George	s C	xon Hil		7: Ond				0 0'''			
Mari 7.28a ed at	9	Tue. Street and Number				101.	Zip Code			'	ug. Citi	zen of Wh	at Coun	tr y ?
h the Maryland 33a or 28a-f sh	澶	5201 Wheeler 1	Road_			2	0745			U	nit	ed St	ate	S
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be notified at once	Funeral Director	11. Marital Status		Decedent Ever d Forces?						fy Yes or No	-	14. Race White		can Indian, Black,
1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.)										A11, 010.7		**IIICO	, 010.	
after al",	by F	3 Widowed 4 NDiv	vorced if Yes, Give or Dates:	Year	1	Yes	2 X No	specify:				Specify:	B1a	ck
nours a	ğ	15. Decedent's Education (Spe		grade complete	d) 16a. Deced		al Occupatio				16b. l	Kind of Bus	siness/Ir	ndustry
2 -	ompleted	Elementary/Secondary (0-12)	Colleg	e (1-4 or 5+)	during	i illost of v	VOIKING INC. L	DO NOT us	se reureu	,				
OS ithin	Ē	12 Secretary Gov 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden S										overnment		
5-00; lled with Hygiene I other t	ပိ											Surname)		
ਹੈ ਜੋ ਕ ਤੋਂ ਦੀ	Be	James H. McMil	James H. McMillian Wilhelmena Greenfield In Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,											
21 buld bulld b i Mer	2	19a. Informant's Name/Relations			19b. Mai	ling Addre	ss (Street	and Numbe	er or Rura	al Route Num	nber, C	ity or Towr	, State,	Zip Code)
and 2 shou fealth and Pitem 27 is r		Tye Magloire /	Daughte	r	2383	3 Per	ring N	Manor	Rd.	Balti	mor	e. MI	21	234
re, MD 212 s 1 and 2 should by f Health and Ment If item 27 is mark		20a. Method of Disposition		2	Ob. Place of Disp crematory or	osition (N	lame of ceme			ate				Town, State
		1 X Burial 2 Cremation	_		·	•	•	1.	- /1 -	/0010	_	•		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Si 21 Signature of Funeral Service	pecify:	<u>_</u>	Harmony	Memo	rial	of Eacilitys	5/1/	/2010	La	ndove	er,	Maryland
Baltimo permit. Page: Department o Important:		A S	AAA	200										ral Home
Physician	-	23a. Part I. Enter the disease, or	complications the	at caused the d	eath. Do not ente	OI/ P	enn. E	uch as card	diac or re	ashing	CON est. sho	ock. or hea	<u> 200</u>	Approximate Interval
/Medical		failure. List only one cause	on each line.								,			Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		osclero	otic car	diova	ascula	r dis	sease				_	Death
			Due to (or a	is a consequer	ce or).									
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or a	is a consequen	ce of):									
	듄	cause. Enter Underlying Cause (Disease or injury that initiated	C						_				- 10	
	Examiner	events resulting in death) Last	Due to (or a	(or as a consequence of):										
760, ficate be executed g physician and the burial - transit			d											
oe exician	//Medical	X UNPENDED	23a P	D TT.27.1	oer ME g	904	5/10/1	ОТТ						
760, ficate by g physic the but	§	IF FEMALE:	23c. If ye	es, outcome of	pregnancy						230	d. Date of		
68 ertifi ding	a	23b. Was decedent pregnant in the past 12 months?	I ' : ''	e birth	-		th 3	Ectopic p	regnancy	,	Ţ	Month	Da	ay Year
Box 68's death certification attending	Physician	1 Yes 2 No 9 ✔ Unl		egnant at time o known	or death 5	Other (S)	pecify)							9
. B. the de y the	흔	Part II. Other significant condit	1.0-	A SOURCE SERVICE	not resulting in th	e underlyi	ing cause giv	on in Part		23e Did to	hacco	use contrib	oute to th	he cause of death?
ires that the signed by						o dilacity.	ing cease giv	ren in r ait						ably 4 V Unknown
S, L	Completed by	Status post	pervic t	umor ex	cision				_					
ords aw requinas been 2 should	Set 1									24a. Was a autop	sy	pr	ior to co	opsy findings available ompletion of cause of
Reco The law cate has	Ē										rmed? 2 ✔ N		eath?	2 No
ital Recision: The section page	ŭ	25. Was case referred to medica	al le				26.Place o	of Death (C	heck only					
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been sed in by the funeral director, page 2 should it	o Be	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatie	ent 3	DOA O	other4 N	Nursing H	ome 5	Reside	ence 6	Other:	Scene
of \ing Phy	-1	27. Manner of Death	28a. D.	ate of Injury	28b. Time of	of Injury	28c. Injury	at Work?	28	d. Describe I	now inju	ury occurre	d	
nding First	Certification:	1 X Natural 5 Pend		onth, Day, Year)			1 Ye	s 2 N	lo					
Sicolar dea	g		estigation 28e P	lace of Injury -	At home farm si	reet facto	ory. office bui	ilding etc.	28	f. Location (S	Street a	nd Numbe	r or Rur	al Route Number, City
지 Suicide 6 Could not be determined Coperity 3 Suicide 6 Could not be determined (Specify)														
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the		4 Homicide 29a. Certifier			1 4 - 4 - 4 - 4		betime date			- 4- 4b	n/n\ nn	d	on state	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial : trans	g	(Check only	hysician: To the aminer: On the bas											
To the vithin To the complete	Medical	29b. Signature and title of certifie	and manne				9c. License							th, Day, Year)
		O TO CONTINUE		200.		ľ	O.C.M					/ 13, 20		,,
		Toh. U	W- 1	OKLA	20		J.O.IVI				ivia)	, 10, 20		
		30. Name and address of person Patricia Aronica-Polla	· ·			111	Dann Str	oot Balti	imere	MD 2120	1			
	لبي	Patricia Aronica-Polla			cal Examiner		i Gilli Olf	sci, Daili	iiiioie,	14ID 2 12U				
St Regis	tate trar	31. Dajujin (Month 2010)	Senera 32	Registra 's Sig	marare Market									
			/											

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ May 20, Jose de Jesus Castillo 2010 1:25p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 17705 Georgia Avenue Olney Montgomery 5. Social Security Number 6. Sex 1 M 2 D F If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. g. Birthplace (State or Foreign Country) DONLINICAN Republic **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Dec. 1921 218-41-2417 88 Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Olney Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17705 Georgia Avenue 20832 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 □ No Specify: Dominican White 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should e filed within 72 l h and Mental Hygiene. 7 is mar ed other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Antonio Castillo permit. Page 1 and 2 should e Department of Heath and Meni Important: If item 27 is mar le any injury or other traumatit. Aracelia Basora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 2 17705 Georgia Avenue, Olney, MD 20832 Teresa Castillo Araujo/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery 2010 20a. Method of Disposition 20c. Location - City or Town, State ₩ Burial 2 Cremation 3 Removal from State Silver Spring, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility lins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a Part 1 Part 1. Inter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Prostate Cancer Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Myelodysplastic Syndrome Examiner Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician a hed for use as the burial-Physician/Medical IF FEMALE: Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 sompleted filled in by the funeral director. autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🖾 🗙 o ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending work? 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29c. License number 29d. Date signed (Month. Dav. Year) \sim \supset D35635 May 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph Kaplan, 18111 Prince Philip Drive, Olney, MD 20832 31. Date filed (Month, Day, Year) State 24 Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registrar 1-Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 14:52 19 rane Shonda 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 4/17/1947 7. Age (In yrs. last birthday) Birthplace (State or Foreigr Country) **Funeral** Days 1 M 2 X F **Director** Pennsylvania 579-68-3138 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show a Director TX Yes 2 □ No traumatic event, the Medical Examiner must be notified Washington or 28a-f DC 10e. Street and Number 10f Zin-Code 10g. Citizen of What Country? 20037 2700 Virginia Ave NW # 1110 items 23a Funeral S. within 72 hours after death Α. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 █️No If Yes, Give Year or Dates: 1 Never Married 2 Married 2 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 Widowed 4X Divorced Specify: 'natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) d 2 should be filed within 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) AT&T Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bertram Roswell Crane ပ Paula Singer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 4913 Langdale CT FT Collins, CO 80526 other <u>Myles Crane</u> Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of He
Important: If iten
any injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 5/26/2010 Falls Church, Va National Crematory 21. Signature of Funeral Service Licence 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave NW Washington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Immediate Cause (Final Onset and Death **Physician** disease or condition resulting in death) ardiac /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P51 S Due to or as a consequence of law requires that the death certificate be executed honic the burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical as attending IF FEMALE: nse s 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal dea 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown for Dav Year 5 Other (specify) detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 2 No 1 TYes 3 Probably 4 Unknow Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 has 1 🗌 Yes 2 No certificate or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 No Other: 4 \(\sum \) Nursing Home 1 Yes 2 ER/Outpatient 3 DOA 6 Other (Specify) ပ 5 Residence this funeral (28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natures
2 Accident 5 Pending investigation Injury n 24 hours after death.

e Funeral Director: After bletely filled in by the ful 1 Tes 2 🗌 No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical npletely (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 title of car 29b. Signature at 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) 30 Name and address 600 North Wolfe St, Baltimore, MD, 21287 V2

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

parked

32

2010

24

Registrar's Signat

seur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mary A. Compton 2010 5:40a M May Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Arcola Nursing Home Montgomery Silver Spring 5. Social Security Number 8. Date of Birth (Month, Day, Year) Mar 24, 9. Birthplace (State or Foreign Country) **Funeral** 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours 1 D M 2 D F Days 100 Yrs.Director 578-20-3237 Ukn Usual Residence of Decedent or 28a-f shov 10a. State 10b. County items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 No Montgomery MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20902 901 Arcola Avenue Ukn 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. . Marital Status Ukn 1 ☐ Never Married 2 ☐ Married Black, White, etc. 6 Yes, Give Ukn ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: **Black** "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 73 fealth and Mental Hygiene. Item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Ukn Ukn Ukn Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ukn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Hungerford Drive 2nd F1 Rockville, MD 20850 Sherry Davis/Guardian 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date Page 1 o <u>=</u> injury or 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 5/28/2010 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute M01463 1040 Rockville Pike, Rockville, MD 23a. Part 1. Prier the dil ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Physician/ disease or condition resulting in death) Coronary Artery Disease Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Mellitus Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed Hypothyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 2 X N Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3[

Box 68760 P.O. Records, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) in Whe Mano 5/7/10 D56691 30. Name and address of person who completed cause of death (Heart 23a) (Type, Print) P.A 12107 Heritage Park Circle, Silver Spring, MD 20906 Ghousia Sultana, MD31. Date filed (Month, Day, Year) 32 Registrar's Signature ORIGINAL

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Carmen F. Castro May 17. 2010 8:46 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug. 10 9. Birthplace (State or Foreign Country) 1942 Venezuela **Funeral** 1 □ M 2 🕱 F Months Days Hours 579-11-2926 **Director** 67 Aug. Usual Residence of Decedent | 10b. Gounty | Maryland | Montgomery 10c. City, Town or Location Rockville or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 No 10g. Citizen of What Country? No. Street and Number 12301 Braxfield Court Apt. 10 et and Numbe 10f. Zip Code 20852 Funeral with within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ğ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Venezuelan If Yes, Give Year or Dates Specify: White Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Financial other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve ance. ျ Regino Castro Dominga Espinel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hernando Acosta / Executor 5611 Lone Oak Drive, Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 1 Cremation 3 Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) May 20, 2010 Alexandria, Virginia Signature of Funeral Service Licensee Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Sensis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cholecystitis Hours Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed burial-transif Cause (Disease or imjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 X No 4 ☐ Pregnant at time of death g ☐ Unknown Day been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Pneumonia, Chronic Renal Failure, Asymetric Septal Completed 1 x Yes 2 □ No 3 □ Probably 4 □ Unknown Hypertrophy, Peripheral Vascular Disease, Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? After this certificate Rheumatoid Arthritis, Pulmonary Hypertension 1 Yes 2 No Yes 2 V or Attending Physician: 25. Was case referred to medical To the Funeral Director: After this certific completed filled in by the funeral director, Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 🗆 XII o Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident ☐ Accider☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d, Date signed (Month, Dav. Year) D29256 10 May 21, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Qui/r/os, MD 4343 Montgomery Avenue, Bethesda, MD 20814 31. Date filed (Month, Day, Yea **WAY 24** ^{Year)} 4 2010 82. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene per FCHD, RG FCHD 6/2/1/10

Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5 Day Year 1)avis harlotte 10.00 AM 20 2010 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Home wood Frederick Frederick If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 T F 86 Yrs 191-16-1307 May 25,1923 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Florida Indian Harbour Beach YEYes 2 □ No Brevard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2225 Highway A - 1A 32937 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X]
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No Specify White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Dowde11 Charlotte Force 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Romane / daughter 2906 Ward Kline Rd./ Myersville, Maryland 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SS Peter & Paul Cem. May 28,2010 | Springfield, PA 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Stauffer Funeral Home, 21. Signature of Funeral Service Licensee 23a. Part 1 fixer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, short in heart failure. List only one cause on each line. 1621 Opossumtown Pike/Frederick, Maryland 21702 Immedia Cause (Final diseas or condition resulting in death) Progressive C Due to gras a consequence of): renal failiure Drogressive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of): CVA Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐ Pregnant at time of death 9☐ Unknown Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 donknown

Physician /Medical **Examiner** burial-trar o <u>م</u> Records,

Physician

/Medical

Examiner

Funeral

Director

ms 23a or 28a-f show must be notified at

or Items 23a

Injury or other traumatic event, the Medical Examiner

Department of I Important: If ite any Injury or of once.

Maryland

Baltimore,

Pages 1 and 2

Director

Funeral

Be Completed by

Examiner Medical Certification: To Be Completed by Physician/Medical

		17N Den	J nentia					24a. Was an autopsy performed? 1□ Yes 2□ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2□ 100
25. Was case referred examiner? 1 Yes 2 No	d to medical	Hospital	1 ☐ Inpatient 2 ☐] ER/Outpatient	(Check only one) ne 5 ☐ Residence 6 ☐ Other (Specify)				
2 Accident	5 ☐ Pending investigation		Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2	280	f. Describe how injury	
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of injury - At h building, etc. (Special	ome, farm, stree	et, fact	28f	. Location (Street and City or Town, State)	Number or Rural Route Number,	
		ysician: To the best of my knowledge, death occurred at the time, date and place, niner: On the basis of examination and/or investigation, in my opinion, death occurred at the state of the basis of examination and/or investigation, in my opinion, death occurred to the state of							

20

Vital 0

Division

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

196 Thomas 32. Registrar's Signature

completed cause of death (Item 23a) (Type, Print)

Johnson Dr #135

29c. License number

DOO6 8811

29d. Date signed (Month, Day, Year)

21702

Frederick

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-03931 State of Maryland / Department of Health and Mental Hygiene Joseph Clinton Dulin, Jr. 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 22, 2010 2348 hrs Medical Examiner JOSEPH C. DULIN, JR. 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 110 West North Avenue, Room 213 **Baltimore** 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7, Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Davs 06/02/1972 Director Country) MD 213-11-5613 1 X M 2 F 37 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No 23a or 28a-f show PRESTON CAROLINE mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland spartment of Health and Mental Hygiene.

portant: If item 27 is marked other than "natural", or items 23a or 28a-5 she jury or other traumatic event, the Medical Examiner must be notified at once. 10f. Zip Code 10g, Citizen of What Country 10e. Street and Number UNITED STATES 110 MAIN STREET 21655 14. Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married 1 X Yes WHITE 1 Yes 2 X No specify: Specify: 4 X Divorced If Yes, Git 990 - 2002 <u>م</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NAVY SEAL U.S. NAVY 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) NANCY L. SATCHELL JOSEPH C. DULIN, SR. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28644 ALMSHOUSE RD., OXFORD, MD STACY DULIN/BROTHER 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 6/8/2010 HURLOCK, MD MD EASTERN SHORE VET. Donation 5 Other Specify FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A 200 SOUTH HARRISON ST., EASTON, MD 21601 21. Signature of Funeral Service License Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and one cause on each line /Medical Death Narcotic (heroin) intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X UNPENDED attending physician for use as the burial -AMENDED 27, PII, 28a-f, per ME G904 6/10/10 TT Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown a signed by the at d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Cocaine use Completed 24b. Were autopsy findings available After this certificate has been a 24a, Was an prior to completion of cause of autopsy performed 1 🗸 Yes ✓ Yes 2 No 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Other₄ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 ✔ Other: Scene 1 Yes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death To the Hospital or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 Yes 2 No Natural Pending Fd 11:35 pm Fd 5/22/10 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town State) 110 W. North Ave Rm 213 Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 X Could not be Suicide hotel room determined (Specify) Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 / Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 32. Redistrar's Signature

ORIGINAL

mel

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

yone

Margarita Korell MD.

31. Date filed (Month, 1) (ea)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

May 23, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Date Month 19, 3. Time of Death Year **Physician** May **2010** 12:35 A M Blaine Eig Herbert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery 12210 Tildenwood Drive Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/29/1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1√2 M 2□ F Washington, DC Yrs 146-18-7613 88 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State or 28a-f show Rockville 1 Xves 2 □ No MD Montgomery Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20852 12210 Tildenwood Drive Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1X Yes 2 □ No WW II If Yes, specify Cuba If Yes, Give and Korean 1 □ Yes 2X No Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 XMarried White Specify þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Medical Physician is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Esther Koenick Sam Eig ൧ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is i any injury or other trau. 12017 Coldstream Drive Potomac MD 20854 Blair Eig - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Olney, MD Judean Mem. Gardens 05/21/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Danzansky-Goldberg Memorial Chapels Inc
II70 Rockville Pike Rockville MD 20852 21. Signature of Funeral Service Licensee M01163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Five Days Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) as the burialphysician Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal dea 4 Pregnant at time of death 3 Ectopic pregnancy Month 5 ☐ Other (specify) I □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 XNo certificate 1 ☐ Yes 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2√ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division of Vital Records, within 24 hours after death To the Funeral Director: completely filled in by the f

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

State Registrar

DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and itle of

31. Date filed (Month, Day, Year) 24 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



and manner stated

29c. License number

D37975

29d. Date signed (Month, Day, Year)

May 19, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month May Day 2010 **Physician** William Donald Elliott 18, 6:26 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 12024 Wishing Well Lane, NE Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month. Dav. Year) Funeral 1 → M 2 □ F Months Days Hours 215-20-7357 84 Director 10/11/1925 Pennsylvania Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location пs 23a or 28a-f show PΔ Bedford Bedford 1 ☐ Yes 2 No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2373 Evitts Creek Road 15522 USA Funeral , or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Pages 1 and 2 should be filed within 72 hours after dinent of Health and Mental Hygiene.

ant: If item 27 Is marked other than "natural", or item ury or other traumatic event, I'm Medical Evansine. Black, White, etc 1 ∑Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. <u>ک</u> 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Hammick Elliott Orma Trene Simon ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mona Lisa Garland / Daughter 12024 Wishing Well Lane, NE, Cumberland, MD 21502 permit. Pages 1 and 2 Department of Health Important: If item 27 any Injury or other tra once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 05/21/2010 Centerville, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1 ☐Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical To the within 2 and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063368 May 19, 2010

MRS

State Registrar

31. Date filed (Month, Day, Year) 2010



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 23 Howard David Franz, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 161 40 4511 1 ፟ M 2 □ F Months Jan. 25, Year 1948 Pennsylvania 62 **Director** Usual Residence of Decedent Show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Maryland Washington Hagerstown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 7 E. Washington Street, Apt. 811 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, þ 1 Never Married 2 Married X Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: white Year or Dates 1967-69 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) carnival laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ruth E. Favinger Howard David Franz, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 Walnut St., Honeybrook, Pa. 19344 Danielle Kristman - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Hagerstown Crematory 5/26/10 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility e of Funeral Service Ligensee MINNICH FUNERAL HOME E. Wilson Blvd., Hagerstown, Md. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ arcinoma disease or condition resulting in death) Medical Due to (or as a consequence of) Examine abstra Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) detached 9 Unknown g Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been signed by to completed filled in by the funeral director, page 2 should be detact. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Inpatient 2 LER/Outpatient 3 IDOA ဂ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 🗌 Pending 1 Natural 1 Yes 2 No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

To the 5H-5+1

State Registrar

W27 31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

29a. Certifier

Oll orchard tenacered Hyperton, 1002/262 itto 111

and address of person who completed cause of death (Item 23a) (Type, Print)

ortifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 0-1062 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 19, Physician/ 2010 5:58 A Ida Domenica Ferrante Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard Brighton Garden Assisted Living Columbia If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 🛣 F oct 1921 Italy 88 **Director** 579-22-5620 Usual Residence of Decedent or 28a-f show notified at 10a. State Maryland 10b. Count 10d. Inside City Limits 10c. City, Town or Location Silver Spring Director Montgomery 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be I Funeral USA 20902 11416 Nairn Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: If Yes. Give Specify: Completed 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home 8 should be filed ware and Mental Hyg ris marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Orsola Fratta Victor Cozzi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8357 Reservoir Road, Fulton, MD 20759 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Santa O. Ottens / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Gate of Heaven Cemetery þ 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State May 24, 2010 Silver Spring, Maryland injury 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc
500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between nset and Death Years Immediate Cause (Final Physician/ disease or condition resulting in death) Essential Hypertension Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Examir burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical death certificate be Box 68760 attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day for Month Year Pregnant at time of death Yes 2 No 1 ☐ Yes 2 ⅓ 9 ☐ Unknown the 9 Unknown detached P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Dementia Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been siç page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hyperlipidemia Physician: The law certificate has autopsy performed? 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Assisted Living Other: 4 \square Nursing Home 5 \square Residence 6 \bigcirc Other (Specify) Facility 2 🗶 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 \square Pending work 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral directors.

Harry Li, MD 8600 Snowden River Parkway, #301, Columbia, MD 21045 31. Date filed (Month, Day, Year) 2010 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practigner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

D56531

29d. Date signed (Month, Day, Year)

May 20, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar amend 20-22 per f.h. g907 Oditicate kin Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day GRIGSBY Physician *a*a:43 2 2010 BABY 04 SIRL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GROVE ADVENTIST HOSPITAL KOCKVILLE SHADY MONTGOMERY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 04 20 Birthplace (State or Foreign Country)
 MARYLAND 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Year) 2010 **Funeral** Months Days 1 ☐ M 2 🕱 F Hours NONE Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County th and Mental Hygiene. ?7 is marked other then "naturel", or lisme 23a or 28a-f ehow traumatic event, the Medical Examinat must be notified at ROCKVILLE, MARYLAND 1 Yes 2 No MONTGOMERY Director filed within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 783 ORCHARD USA QUINCE Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: 3 ☐ Widowed 4 ☐ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) INFANT NFANT Ø 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h 19b. Mailing Address (Street and Number or Aural Route Number, City or Town, State, Zip Code) 2 19a. Informant's Name/Relationship (Type, Print) QUINCE ORCHARD #12, N. POTOMAC, MD 20878 Pages 1 and 2 JUDY GRIGSBY/MOTHER Department of Health a Important: If Item 27 is eny injury or other tra-20c. Location - City or Town, State Alexandria, Va 20b. Place of Disposition (Name of cer Mer property in pamplace) 20a. Method of Disposition 6/23/10 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STERI 05/20/2010 HALL RIVER, NC CYCLE MD20850 21. Signature of Funeral Service Licens Jahad Ahmad Meteropotitum Funeral Service, Va. 9901 MEDICAL CENTER DRIVE, ROCKVILLE Rhodora 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, EXTREME PREMATURITY Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetel death 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) P.O. F signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed been si 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate 1 ☐ Yes 2 No of Vital Physician: To the Hospital or Attending Physician: within 24 hours efter death.
To the Funeral Director: After this certific completely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 XInpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Division 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD69801

State Registrar

DHMH 17 Rev 1/2001

MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MECHELE SILVA, 9901, MEDICAL CENTE

Registrar's Signatu

Amend 20b, 20c WCHD/SH 6/1/2010per FH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 31 State of Maryland Department of Health and Mental Hygiene FoAmend Item 31 State of Mar State WCHD/SH 5/27/10 per VR Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 25, ^{Day}2010 9:16A. M **Guendel** Kenneth Alan Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington 29 Yankee Drive **Keedysville** 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months July 29, Year 1954 NewYork 55 Director Yrs. 25-42-3660 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 X Yes 2 No Maryland Washington Keedysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 29 Yankee Drive U.S.A. ural", or items? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sports and Fitness of Health and Mental Hygier If item 27 is marked other I r other traumatic event, th Tennis Professional Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental fitem 27 is marked ည Walter Cornelius Guendel Janet Helen Fryba 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aleshin / Wife 29 Yankee Drive Keedysville, Maryland Lydia 21756 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o Fairview Cemetery Boonsboro Cemetery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Keedysville MD Boonsboro, Mary 4 ☐ Donation 5 ☐ Other (Specify) 05/29/2010 21. Signature of Funeral Service Licent 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 23a. Part 1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each ine. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ econds Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Lisease or iinjury that initiated events resulting in death) Last non-small cell) cancer Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year g 🗌 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? þ Cerebrovascular Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☑ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Inpatient 2 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier MD D0067442 5/25/2010 46 Thomas Johnson Drive, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SH-10 Frederick, Maryland trar's Signature Registrar

10-04154 Daniel L. Gaum	or	Ple		or Print in B				•		egibl	e.		
Daniel L. Gaun	eı	1- For State	Stat	e of Maryland	-	ment of H ficate of D		nd Mental F	rygiene		2016	739	
Physici	an/	Registrar 1. Decedent's Nam	ne (First Middle I	ast)	- Certif	ncate of D	Galli		2. Date of De	Reg. No).	3. Time of Death	
Medical Exam				·					Month May 31,	Day	Year	1324 hrs	
				give street and number	r)	4b.	City, Town, o	or Location of Dea			c. County of Deatl	1	
		Western M	aryland Regi	onal Medical Cen	ter	C	umberlar	nd		- 1	Allegany		
Funeral		5. Social Security I	Number 6.	Sex 7. A	ge (In yrs. last		f Under 1 Ye			irth(MN	1/DD/YYYY) 9. Bir Foreig		
Director		189-44-9	899 1	XM 2 F		49 Yrs.	Months Da	iys Hours Mi	Sept.	. 2,		puntry) PA	
y		Usual Residence of			Idon City To	own or Location						Land to the City I is the	
ow an			10b. County								10d. Inside City Limits 1 X Yes 2 No		
yland a-f sh	ţċ	MD 10e. Street and Nu	Garret	<u> </u>	Grant	sville	of Zin Codo		10g. Citizen of What Co				
ie Mai or 28	Director	75.75				10f. Zip Code 21536					nu y r		
vith th s 23a e.notij		131 Gra	IIIL SL.	12. Was Deceder	t Ever in U.S.			lispanic Origin? (\$	Specify Yes or N	US.		ican Indian, Black,	
eath v item	Funeral	1 Never Marri	ed 2 X Marri	ed Armed Forces		specify Cuba	an, Mexican, Puert	o Rican, etc.)		White, etc.	real main, black,		
ifter d il", or	yΕι	3 Widowed	4 Divorc	ced If Yes, Give Year or Dates:	NO NO	1 Ye	s 2 X N	o specify:			Specify:	White	
ours a	Completed by	15. Decedent's E	ducation (Specify	only highest grade co	mpleted) 10			ation (Give kind of e. DO NOT use re		16b.	Kind of Business/	Industry	
6 n 72 h an "n ical E	lete	Elementary/Seco	ondary (0-12)	College (1-4 or	5+)	_	_		urea)				
003 within giene.	omp	12	/F:			Truck	Driver				rucking		
15- filed al Hyg ed off	Be C	17. Father's Name Clarence		ist)				18.Mother's Nam June I		Maider	i Surname)		
MD 21215-0036 and 2 should be filed within 7 alth and Mental Hygiers m 27 is marked other than aumatic event, the Medica	.0 B	19a. Informant's Na		(Type, Print)		19b. Mailing Ad	dress (Stre			ımber. C	nber, City or Town, State, Zip Code)		
AD 2 sho h and 27 is imati		Maxine G	Saumer/W	ife	1			4, Grants			21536	, -,,	
e, F. I and Healt Healt item		20a. Method of Dis				ce of Disposition		emetery,	Date	20c.	Location - City or	Town, State	
TOF Pages ent of nt: If			Other Spec	3 Removal from S	Sali	sbury C	emeter	cy Jun	e 4, 20	1þ s	Salisbury	, PA	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martlel Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu				22. Name	and Addres	ss of Facility Ne	wman Fu	ner	al Homes	, P.A.	
E P P D		11.00		ema		P.0	Box	275, Gra	antsvill	e,	MD 2153		
Physician		23a. Part I. Enter It failure. Sist on	ne disease, of con ity one cause on	mplications that caused each line.	the death. Do	o not enter the m	ode of dying	g, such as cardiac	or respiratory ar	rest, sh	ock, or heart	Approximate Interval Between Onset and	
/Medical Examiner		Immediate Cause (a Hypertensive A		otic Cardiova	scular Di	sease				Death	
		or condition resulti		Due to (or as a cons	equence of):								
	ē	Sequentially list co if any, leading to in	nmediate	Due to (or as a cons	equence of):								
	Examiner	(Disease or injury t	hat initiated	c. Due to (or as a cons									
ansit		events resulting in	,	d.	equence or).								
cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	ical	UNPENDED		AMENDED									
'60, ate be	sician/Med	IF FEMALE:		23c. If yes, outco	me of pregnan	ncy				23	d. Date of delivery	,	
687 ertific ding 1	ian/	23b. Was decedent past 12 months		1 Live birth	والمعادلة والمعادلة والمعادلة والمعادلة والمعادلة والمعادلة والمعادلة والمعادلة والمعادلة والمعادلة والمعادلة	2 Fetal d	eath 3	Ectopic pregn	ancy		Month D	oay Year	
Sox leath c	/sic	1 Yes 2 1	No 9 Unkno		t time of death	5 Other	(Specify)						
O. Et the chart by the ached	Phys	Part II. Other signi	ficant condition		h but not resu	Iting in the under	rlying cause	given in Part I.	23e. Did t	obacco	use contribute to	the cause of death?	
P.(Completed by	Obesity							1 Ye	s 2	No 3 ✔ Prob	ably 4 Unknown	
rds requi been hould	ete								24a. Was			topsy findings available	
eco ne law te has ge 2 s	Ę								auto perfo 1 ✓ Yes	ormed?	death?	ompletion of cause of	
Vital Reco hysician: The law this certificate has I director, page 2 s	ပိ	25. Was case refer	red to medical				26.Plac	e of Death (Check		Z N	lo 1 🗸 Ye	s 2 No	
Vita ysicia direct	To B	examiner? 1 ✓ Yes	2 No	Hospital: 1 Inpatio	ent 2 🗸 ER	VOutpatient 3	DOA	IOthor:	ng Home 5	Reside	ence 6 Other	:	
n of ing Ph		27. Manner of Deat		28a. Date of Inju (Month, Day,)	ury 28	b. Time of Injury	28c. Inju	ury at Work?	28d. Describe	how inj	ury occurred		
ion trendi leath. tor:	읉	1 Natural 2 Accident	5 Pending Investiga				1	Yes 2 No					
ivision or Attent after death Director:	Certification:	3 Suicide	6 Could no	ot be 28e. Place of Ir	njury - At home	e, farm, street, fa	ctory, office	building, etc.	28f. Location (or Town,		and Number or Ru	ral Route Number, City	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri		4 Homicide 29a. Certifier	determir	ned (Specify)									
he Ho in 24 he Fu pletely	ca	(Check only one)		ician: To the best of m er:On the basis of exa									
To t With Com	Medical	2)2	title of certifief	and manner stated.			29c. Licens			_	Date signed (Mor		
		//		Day D				M.E.			e 1, 2010	in, Day, real)	
	(30 Name and addr	ess of person wh	o completed cause of	eath /Item ??	a)	J			1 3 3 11	, =010		
	10	Laron Locke		istant Medical Ex	,	•	eet, Baltii	more, MD 212	201				
S	ate	31. Date filed (Mont			r's Signature	1 1	1.1						

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EDNA PRICE GANNON MAY 11, 2010 9:25 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WILLIAM HILL GARDENS EASTON TALBOT If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 K F 220-34-7689 96 Director 12/31/1913 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show event, the Medical Evaminer must be notified at 1 ☐ Yes 2 No Director MD TALBOT EASTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 any injury or other treumatic event, It. Medical Exerciting must be song. Funeral 9704 LONGWOODS ROAD 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 MNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No WHITE Specify. 9 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES EDWARD PRICE CLARA ANDREW ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29110 AIRPORT ROAD, EASTON, MD 21601 CECIL H. GANNON, SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State SPRING HILL CEMETERY 5/17/2010 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee JOHN R. MERCERON 200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** É pairel 2 wks disease or condition resulting in death) im /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2XNo 3 Probably 4 Unknown Alzheimers Denentia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 st 24a. Was an Advance Age 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Stather (Specify) Asst. Living 1 Yes 2 No After this c funeral dire 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie within 24 hou To the Fune completely fi 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) til I. Show CRNP R077623 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lune Easton, MO 2160/ RS6 Thomas CANP 501 Dutchmale 31. Date filed (Month, Day, Year) MAY 13 2010 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gordon Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death oncaster Talbot Eacton If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F 06/26/1950 Country) 59 Director 220-44-2346 MD Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD TALBOT **EASTON** 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8443 DONCASTER ROAD 21601 UNITED STATES death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: "natural" Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 5+ LAWYER LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishership pe ALEXANDER GORDON, III permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic. D'ARCY HILLES 19a. Informant's Name/Relationship (Type, Print)

WALTER B. GUNBY/ REPRESENTATIVE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 MARKET SQUARE, CAMBRIDGE, MD 21613 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION 05/13/2010 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON ST., EASTON, MD 21601 P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Coronary Vaccular disease or condition earc Medical resulting in death) Years Examiner te if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine sician and burial-trans resulting in death) Last Physician/Medical that the death certificate be the use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No detached 9 Unknown 9 Unknown P.O. sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, or Attending Physician: The law requires Completed 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available 24a. Was an has autopsy performed? Yes 2 No prior to completion of cause of death?

1 Yes 2 No certificate Division of Vital director, 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? 1 Yes 2 2 🗌 No 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury 24 hours after death. Funeral Director: A Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Settlifying Priystoan. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. only one 29b. Signature 29d. Date signed (Month, Day, Year) eted cause of death (Item 23a) (Type, Print) Centre Blud, #1111 10 RS State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. = State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Merla Irene Gardner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western MD Regional Medical Center Allegany Cumberland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔽 Months Days Hours Min (Month, Day, Year) 232-60-5661 72 Director 10/05/1937 West Virginia Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he motified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director WV Mineral Ft. Ashby 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Patterson Creek Drive, P.O. Box 1270 26719 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Divorced Completed Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teller Banking Be 17. Father's Name (First; Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Cyrus Whitacre Helen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 1270, Ft. Ashby, WV 26719 David J. Gardner / Husband 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🏻 Cremation 3 ☐ Removal from State Cumberland Crematory! 05/25/2010 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, I.A. gn ture of Funeral Service Lice 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ SEPSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Treater Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by INFARETION MYOCHRDIAC 1 Tes 2 No 3 Probably 4 Nown ABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 GLIUBUTION A MALICNANT 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 1 Department 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 🗌 Yes Accident 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year, D4205 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAS 912 Seton Drive, Cumberland, MD Donaldson, M.D., 21502 Gregg C.

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) MAY 25 2010

32. Registrar's Signature

MCG
E
4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

/			For State Registrar		State	of Ma	ryland			ent of F ate of D			Mental Hy	/gien Reg. N		79	00
	Dhysisia	· · · /	1. Decedent's Name (First, M		,								2. Date of D	eath		3. Time of E	
	Physicia Medic	al	Doris F. Gol										May	19,	^{0a} 2010 ^{Year}	5:00 P	М
	Examin	er	4a. Facility Name (if not institu 5225 Pooks H			,	S.			ty, Town, or thesd		n of Death		4	c. County of Dea Montgon		
	Funeral Director		5. Social Security Number 214-20-5728	6. 5	ex □ M 2 F		(In yrs. Ias 84	st birthday) Yrs.	If Und Month	der 1 Year s Days	If Und Hours	er 24 Hrs. Min.	8. Date of Bi	rth ay, Yeg r)	9. Bi	rthplace (State or .	Foreign
	or at	_	Usual Residence of Decedent 10a. State 10b. Co.			· .	10c City	Town or Lo	cation							10d. Inside City	. (!==!)=
	larylar 3a-f sl ified	ecto		-	omery			kvill								1 X Yes 2	
	the M	ä	10e. Street and Number	01108	ome z y		1100			Zip Code				10g. C	Citizen of What C		
	h with	Funeral Director	10538 Tucker	man	Heights	Cir	cle		2	.0852					U.S.A	•	
30	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: I fire AZ is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	β	11. Marital Status 1 Never Married 2		12. Was Dec Armed Fo 1 Yes If Yes, Gi	orces?			f Yes, sp	edent of Hi ecify Cuba 2 🐴 No	n, Mexic	an, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi Specify:	te, etc.	
9500-c	atura cal E	Completed	3 ☐ Widowed 4 🛣 Divo	_	Year or D			16a. Dece						T 401		White	
0.7	n 72 h e. ian "n Medi	ldm		ighest gr	ade completed College (1	<u> </u>	-	(Give	kind of v	ork done a se retired)		ost of work	ing	166.	Kind of Business	Industry	
7	d withi lygiene her th nt, the	Be Co			3	3	\perp		Owne	r				Co	urt Repo	rting Fi	rm
yland	id be file Mental H arked ot atic ever	To B	17. Father's Name (First, Midd Isaac Feld	lle, Last)									ne (First, Middle Mensh	, Maider	n Surname)		
Nar.	shour and 7 is m		19a. Informant's Name/Relati													p Code) 2081	
υ U	and 2 Health tem 2		Ira Steven G 20a. Method of Disposition	olds	tein/So	n	20h Pia	5225 ace of Dispo			111				thesda, Location - City o	Maryland	<u> </u>
Dallimor	. Page 1 tment of tant: If ii jury or c		1 🔀 Burial 2 🗌 Crema 4 🔲 Donation 5 🗌 Oth		fy)	1	Gard	netery, crer en 0f	natory of Ren	other plac nembra		5/2	Date 1/2010	C1	arksburg	, Maryla	and
Q	permit Depar Impor any in	(9	21. Signature of Funeral Serv		300	MO15 Gr	eenh	11 t							r ection, le, Mary	land 208	352
			23a. Part 1. Enter the disease shock, or heart failure. L	e, or com	plications that ne cause on ea	caused th ach line.	he death.									Approximate Interval Between	
-	nysician/ Medical	í	Immediate Cause (Final disease or condition resulting in death)			brov (or as a c		lar D	isea	se						Onset and De	eath
	Examiner	-K	Sequentially list conditions,		b. Deme	ntia											
	red nsit	Examiner	il any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	<		(orașa o		iction									
	cate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last			(orasa o											
3	ate be	edical		•	d										-		
3	certific nding puse as	J/M	IF FEMALE: 23b. Was decedent pregnant		23c. If yes, our				,						23d. Date of de	liver/	
	Actending Physician: The law requires that the death certific ar death. sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 🙀 No 9 ☐ Unknown		1 Live 4 Preg 9 Unki	nant at ti			Ectopio Other (pregnancy specify)	У	_			Month	Day Yea	ar
,	ries that t signed b d be deta	þ	Part II. Other significant con Diabetes	ditions c	ontributing to d	death but	not result	ting in the u	nderlyin	g cause giv	en in Pa	rt I.				the cause of dea	
5	v requires the second second be to should be to should be to second seco	olete	Hypertension										24a. Was	_	24b. Were au	topsy findings ava	ailable
ָּ בַּ	Ine law ate has page 2	Completed	Osteoporosis										auto perfo 1 🗆 Yes	psy ormed?	death?	completion of causes 2 🔀 No	ise of
	certificate ector, pag	Be	25. Was case referred to medi examiner?		Hospital:					T		eath (Checi		2	101	2 2 110	
	ral dir	2	1 Yes 2 X No 27. Manner of Death		1 28a. Date	_		R/Outpatien 8b. Time of	t 3 🗆		4 📖				6 Other (Spec	eify)	
	ending sath. or: After he fune	ficate		estigation	(Mon	th, Day, Y	/ear)	injury	М	28c. Injury work?	? Yes 2[28d. Describe I	now inju	ry occurred		
	al or Atte	Certificate:		uld not b ermined	28e. Place	of Injury ing, etc. (\$		e, farm, stre	et, facto	ry, office			28f. Location (City or Tov			ral Route Number,	;
	or the Osptial or Attending Prysician; within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 \bigsqcup Medic	al Exam	ner: On the bas	sis of exar	mination a	ind/or invest	igation, i	n my opinio	n, death	occurred at	the time, date a	and place	nd manner as sta e, and due to the (s) and manner as	cause(s) and mann	er stated.
i i	Vithin To the comp	- 7	29b. Signature and title of cert	ifier				nowledge, c		c. License			e, and due to tr		(s) and manner as ate signed (Mont		
	20		▶ U.	Al	dn	an	7	nh		D3780)1				May 20	2010	
			30. Name and address of pers														
	State	e	Aimee Seidma 31. Date filed (Month, Day, Yea	ır)	D. 150	020 S legistrar's	Shady Signatur	Grov	e Ro	oad,	Suit	e_300	, Rocky	vill_	e, Mary	Land 2085	0
	Registra	-	MAY 24	2010	Pen	مهر	A.	frav									

DHMH 17 Rev 7/2009

.

10-03864 James Hogston Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

7	0	Landy	17		9	\cap
		i i		1	2	U

		1- For State			Certific	ate of	Death			6	en No			
Physici	an/		lle,Last)							2. Date of Dea				3. Time of Death
		James Michael	Hogston							Month May 20 2	Day 2010	Year		1149 hrs
			-	umber)		41	b. City, Town,	or Loca	ation of Deat			c. County o	f Death	
							Cheverly				- 1			's
Euporal		5 Social Security Number	6 Sex	7 Age (1	n vrs last bir	rthday)	If Under 1 Y	ear If	Under 24Hr	s IR Date of Ri	rth/8484	/DD//////	9 Rin	holace (State or
		· ·			-			_		, 			Foreig	n Cheverly, MD
			1XM 2 F	4		Yrs,				January	7 21,	, 1965	Cot	untry)
ě:				110	City Tour	or Locatio								40d Inside City Limite
				1	-									•
Physician/ 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Year May 20, 2010 4a. Facility Name (if not institution, give street and number) Prince Georges Hospital Center 4b. City, Town, or Location of Death Cheverly 4c. County of Death Prince George's Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Day Year May 20, 2010 4c. County of Death Prince George's 4c. County of Death Prince George's														
Mary 28a- d at	ect	10e. Street and Number					•			1	10g. Cit	tizen of Wha	at Coun	try?
the ?	ō	5411 Quintana	Street	h.			20	737	7			USA	A	
with ns 23	ral	11. Marital Status			er in U.S.)-			can Indian, Black,
leath r ite	m	1 X Never Married 2 M	airieu		No	If Ye	s, specify Cub	an, Me	xican, Puerto	Rican, etc.)		White,		
ffer fr. o		3 Widowed 4 Div	orced If Yes, Give Ye		110	1 🗍 '	Yes 2X N	lo sp	ecify:			Specify:	Whi	.te
ours a	d b	15. Decedent's Education (Spe	cify only highest gra	ide comple	ted) 16a.						16b.	Kind of Bus	iness/Ir	ndustry
72 ho	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)				fe. DO	NOT use ref	ired)		_		
O36 Ithin	Idu	12				Dri	ver					Furni	tur	e
ed wi	်	17. Father's Name (First, Middle,	, Last)					18.M	lother's Nam	e (First, Middle,	Maiden	Surname)		
215 be fill htal H ked	3e (Willard Thomas	s Hogston					Di	lane L	. Caldwe	e11			
21 Mer mar		19a. Informant's Name/Relations	ship (Type, Print)		19	b. Mailing	Address (Str	eet and	d Number or	Rural Route Nur	mber, C	ity or Town	, State,	Zip Code)
AD 2 sho		Diane L. Hogs	ton / Mot	her		5411 (Quintar	na S	Street	. River	la1e	e. MD	207	37
and and Health					20b. Place	of Disposit	ion (Name of c				_			
Or ges 1 t of F		1 X Burial 2 Cremation	n 3 Removal f	rom State					5/	27/2010	R.	ontrio	o.d	Manusland
timen trant					FOLL					27/2010	DI	entwo	υα ,	Maryland
3al ermi pepar nijury			4/39 Baltimor								ore Avenue			
	_	Jan 14												
				caused the	death. Do n	ot enter the	e mode of dyin	g, such	as cardiac o	or respiratory arr	est, sh	ock, or hear	t	
		Immediate Cause (Final disease	a. Seizu	re di	sorde	r								Death
		or condition resulting in death)	Due to (or as	a conseque	ence of):							-		
			b											
	ii.	cause. Enter Underlying Cause		a conseque	ence of):								i	
	am			a conseque	ence of):									
uted nd ransi1		, <u></u>	d.											
exec ian a	<u>s</u>	X UNPENDED	AMENDED	T 07	00 6		349 04	~	. 100 11					
60, te be bur	9	IF FEMALE:	23a,PI	outcome o	Z8a-T	, per	ME gy	<u>)4 (</u>	5/30/1	O TT	23	d Date of d	elivery	
187 rtifica ing p		23b. Was decedent pregnant in the					death 3	E	ctopic pregna	ancy			-	ay Year
th ce	<u>i</u>			nant at time	of death	\equiv								
Bc e dea ed fo	اج	T Yes 2 No 9 Unk	known 9 Unkn	own										
od by etach		Part II. Other significant conditi	ions contributing t	o death bu	t not resultin	g in the un	derlying cause	given	in Part I.				_	_
signe		Cocaine use,	hyperten	sion	cirr	hosis				1Ye:	s 2 🗸	/ No 3 _	Proba	ably 4 Unknown
required been nould	ete													
CO law has	린													ompletion of cause of
The The	Ŝ.]	2 N	lo 1 e	✓ Yes	3 2 No
certi:			11											
hysi al dir	2												,	
ing P After		1 Natural	28a. Date (Monti	of Injury n, Day, Year)	28b.	Time of Inju	·							
ion trend leath. tor:	읉	- Hattildi 5 Pend		, 200	8 un!	k	1	Yes 2	2 X No	subjec	t s	truck	by	auto
VIS or At fter d Direc	<u>≅</u>		28e Plac			arm, street,	factory, office	buildin	ng, etc.			and Number	or Rur	al Route Number, City
Dital purs a strail I	딅	. deter		unk							itate)			
Hosp 24 ho Fun			111		owiedge, dea	ath occurre	d at the time,	date an	nd place, and	due to the caus	e(s) an	nd manner a	ıs state	d.
o the ithin o the	흥	one) 2 Medical Exam			tion and/or i	nvestigatio	n, in my opinio	n, deat	th occurred a	at the time, date	and pla	ace, and du	e to the	cause(s)
E S E S	\$	29b. Signature and litle of certifie) /	0.00	W.	29c. Licer	se num	mber		29d.	Date signed	(Mon	th, Day, Year)
		7. th 6/ 1	4	///	198	V	0.0	.M.E.			May	y 21, 201	0	
2	4	20 Name and address of	en 4ee	Le-	Utar 00 i									
4.41	-					111 Da	nn Stroot	Raltin	more MD	21201				
			.,			mre	Jueet,	Jailii!	HOIE, IVID	Z 1 Z V I				
			1	Jana 3 3										
DHMH 17 Rev 1/20		MAI O CUIU	- Comment	10. 1		IGINAL								
OCME ODGO			OCME		UK	JAMIO								

10-03354 Joseph Janowiak Amend 20b per FH G905 7/22/10 dk
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

1	6	5	0	0
	- 1	Feed	1 /	-/
	1		1.1	

		1- For State Registrar		C	ertific	ate of i	Death			- Re	eg. No.			
Physici Medical Exami	an/	Decedent's Name (First, Middl Joseph	le,Last)		Jano	wiak				2. Date of Deat Month May 1, 20	Day	Year		ime of Death 805 hrs
		4a. Facility Name (if not institution 664 lvy League Lane	on, give street and n	umber)		46	. City, Town, or Rockville	Location	of Death		4c. Co	unty of De tgomer		
Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birt	hday)	If Under 1 Yea	_	er 24Hrs.	8. Date of Birt	th(MM/DD/		Birthplac	ce (State or
Director		224-90-8343	1 X MM 2 F	53		Yrs.	Months Day	s Hours	s Min.	May 4	, 195	6	Country	Germany
any		Usual Residence of Decedent 10a, State 10b, County		10c. C	itv. Town	or Location	n						10d.	Inside City Limits
* .	L	Maryland Montgo	omerv		•	ckvil							1 [Yes 2 No
Maryland 28a-f show datonce.	Director	10e. Street and Number	J				10f. Zip Code			10	0g. Citizen	of What C	Country?	
the N 3a or 2		664 Ivy League	Lane				20850)			USA			
5 72 hours after death with the Maryland 1" natural", or items 23a or 28a-f sho 1-al Examiner must be notified at once.	Funera	11. Marital Status 1 Never Married 2 Maried 2 Maried 2 Married 2 M	12. Was De arried Armed F	cedent Ever in orces?	U.S.		Decedent of His s, specify Cubar					Race - Ar White, etc		ndian, Black,
			1 Yes	2 No)	1 \	res 2 X X No	specify:			Spe	cify: W	hite	
ours af atural camin	d by	15. Decedent's Education (Spec	or Dates:			Decedent's	Usual Occupat	tion (Give	kind of wo		16b, Kind	of Busine	ss/Indust	try
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	Completed	Elementary/Secondary (0-12)	College (2 years	1-4 or 5+)		-	st of working life lever Wo		use retire	u)				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	No.	17. Father's Name (First, Middle,		-	<u> </u>			18.Mother	's Name (I	First, Middle, N	Aaiden Surr	name)		
21215 Uld be file Mental H marked o	Be	Joseph C.	Janowial	K Sr.					Helen					
ore, MD 2121; es I and 2 should be fil of Health and Mental B If item 27 is marked her traumatic event,	٩	19a. Informant's Name/Relations Helen Janowiak		ner	- 1		Address (Stree					-		
and 2 and 2 fealth 2 frem 2			•		b. Place o	f Dispositi	arley L on (Name of cer	metery,		Spr.Tiig:	20c. Loca			20746 n, State
imore, MD 2121 Pages I and 2 should be fi nent of Heath and Mental ant: If item 27 is marked or other traumatic event,		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Sa	n 3 Removal f	rom State Ar	·1 ing	ton N	fational	L	7/26	5/2010	0хо	n Hil	L1, M	Maryland
Baltimore, permit. Pages I ar Department of Hee Important: If ite	1	21. Signature of Funeral Service	Licensee			22. Nai	me and Address	of Facility	y Geo	roe P	Kala	s Fur	neral	Home PA
	4	25a. Part I. Exter the disease or	Ms	accord the dec	ath Door	010	U Uxon	HIII	Kd.	Oxon H:	ill, I	Mary]	Land	20745 proximate Interval
Physician /Medical	Į	failure. List only one cause	on each line.				mode or dying,	Such as C	arulac or i	espiratory arre	est, shock,	or rieart		etween Onset and Death
Examiner	-1	Immediate Cause (Final disease or condition resulting in death)		zure di a consequence		eı							12	
	اير	Sequentially list conditions, if any, leading to immediate	b.	a consequence	e of):								-	
	Examiner	cause. Enter Underlying Cause	С				- 1- 10-10-							
nted d ansit		events resulting in death) Last	Due to (or as a	a consequence	e of):									
760, icate be executed physician and the burial - transit	ledical	X UNPENDED	¬	7,28a-f	,per	ME g	3904 6/1	0/10	TT					
Box 68760, e death certificate be the attending physic of for use as the bur	≥	IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes,	outcome of pr	egnancy 2				pregnanc	;y	23d. Da Mor	ite of deliv	very Day	Year
Box 687 te death certifi the attending	Physician	past 12 months? 1 Yes 2 No 9 Unk	4 Preg	nant at time of			(Specify)							
D. Be the de by the	Phy	Part II. Other significant conditi	9 Ulkii		t resulting	in the und	derlying cause g	iven in Pa	art I.	23e. Did to	bacco use	contribute	to the ca	ause of death?
of Vital Records, P.O. B. R. Physician: The law requires that the de wher this certificate has been signed by the meral director, page 2 should be detached in a standard of the detached in t	ρ									1 Yes	2 🗸 No	3 🔲 F	Probably	4 Unknown
ords, w requir	Completed									24a. Was a				findings available etion of cause of
Reco	E									perform	med?	death 1	1?	2 No
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medical examiner?	Hospital: E						(Check on					
f Vit Physic ral dir	<u></u>	1 Yes 2 No 27. Manner of Death	Hospital: 1	Inpatient 2	=,	itpatient :		Other ₄	-	Home 5 I	Residence		ther: Scer	ne
ion of tending Ph eath. or: After the funeral	ij	1 Natural 5 Pend	Monti) ding تا	h, Day,Year)		•	1 1 7	es 2X	No.	ınk	ion injury o	0041104		
Division tal or Attendir rs after death.	ertification:		angunon	/1/10 ce of Injury - At		5:53 rm, street,	pm factory, office b	uilding, et	_	8f, Location (S				oute Number, City
Divisor appearance of the properties of the prop	Cert	4 Homicide deter	rmined (Specify)	hous	e				I	Rockvil	1e, N	DTAA	Lea ——	gue Lane
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	edical	(Olivon oliv)	nysician: To the be miner:On the basis	of examination	_									se(s)
To Wil	Me	29b. Signature and title of certifie	and manner s	stated.			29c. License	e number			29d. Date	signed (Month, D	ay, Year)
		Mayara D	he Shul	l			O.C.I	И.E.			May 2,	2010		
	-	30. Name and address of person Margarita Korell MD.	who completed cau Assistant Me			111 Per	nn Street, Ba	altimore	. MD 21	201				
St	ate	31. Date filed (Month, Day, Year)		egistrar's Signa					., 2 1					
Regist		JUN 0	8 2010 L	h trock	S.	ba	Kel							
DHMH 17 Rev 1/2	001			-	OR	GINAL								

Jeffery Charles Justice

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

010 1790

450	Type of I fine in Di	aon maonaio ma		p.00 /
	State of Maryland	Department of He	ealth and Menta	l Hygiene

1- For State Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle Last) Physician/ Month Day May 22, 2010 2208 hrs Medical Examiner Jeffery Charles Justice 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (if not institution, give street and number) WMHS Willowbrook Road Allegany Cumberland If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** oreign Months Davs Hours Director Aug. 12, 1978 countryFlorida 262-89-3938 31 Yrs. 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No 28a-f show Salisbury PA Somerset Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Medical Examiner must be notified at once. or items 23a or 28a-f sho must be notified at once. Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 15558 9257 Mason-Dixon Hwy. Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No 1 Yes White 1 Yes 2X No specify: 3 Widowed 4 X Divorced Yes, Give Year Specify: ģ 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired)

Computer Tech. & Graphic Elementary/Secondary (0-12) College (1-4 or 5+) Electronics Co. Designer 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Mary June Johnson Be Charles A. Justice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ပ P.O. Box 422, Salisbury, PA 15558 Mary June Justice/Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State May 27, 2010 Salisbury, PA Salisbury Cemetery Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes, P.O. Box 275, Grantsville, MD 23a. Part I/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Medical failure. List only one cause on each line. Between Onset and Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial - tran Physician/Medical AMENDED 28a-c, 28f, per ME G904 6/23/10 TT UNPENDED Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Month Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a Wasan prior to completion of cause of autopsy performed? death? ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. 26.Place of Death (Check only one) 25 Was case referred to medical Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Driver auto auto collision 1 Natural 1X Yes ZV NO Director: 5 Pending 5/22/10 2049 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be 24 hours a determined (Specify) Major Road / Highway Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical To the l within 2 To the F 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) May 23, 2010 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

DRIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Kahl uraye 6:45A M /Medical May 28 2010 4a. Facility Name (If not institution, give street and humber) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospital
. Age (In yrs. last birthday) Garrett Co. 5. Social Security Number Memorial Garrett Oak Land **Funeral** 8. Date of Birth (Month, Day, Year) 6/29/1939 9. Birthplace (State or Foreign 1□M 2 F Months West Virginia Days Hours Min. 70 Yrs. Director 220-38-0132 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Director 1 XYes 2 □ No MD Garrett Oakland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 5th Street 107 S. 21550 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🔀 No Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If them 27 is marked other than any injury or other traumatic event, the Manging. Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Special Education Asst. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ George R. Nordeck Elizabeth Hoye 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda R. Sipe/ Daughter P.O. Box 413, Prince Frederick, MD 20678 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Countryside Crem. 5/29/2010 Davidsville, PA 22. Name and Address of Facility Newman Funeral Homes p.A. 203 S. 2nd St., Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (ce of) sician and burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day signed by the a d be detached for 5 Other (specify) 1 ☐ Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ icate has been sign, page 2 should b Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 2 🗆 No 1 ☐ Yes 2 XXIIo 1 ☐ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭∑No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year) JUN - 1 2010

Daniel Bucking tram

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sulel 32. Registrar's Signature

255 W Fourth

064302

Oakland MD 21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GEORGE KARYDES 1305 M May 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Talbot Easton Hospita Memoria Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 X M 2 🗆 F Months Days 0771371930 336-24-1351 79 Yrs Director Usual Residence of Decedent 10a. State 10b. County permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 126 SOUTH HARRISON STREET 21601 UNITED STATES Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: WHITE 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWNER RESTAURANT 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ ANDY KARYDES FOTIKA PROPHETS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KAREN HUSTON KARYDES/WIFE 126 SOUTH HARRISON ST., EASTON, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State CHESAPEAKE CREMATION 05/15/2010 1 Burial 2 X Cremation 3 Removal from State STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
200 SOUTH HARRISON ST., EASTON, MD 21601 NHON Z ERCERON 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final hemorrhage Onset and Death Physician tntracercloral disease or condition resulting in death) Medical Due to (or as a consequence of) 10 Examiner Sequentially list conditions, day, leading to infried cause. Enter Underlying Cause (Disease or linjury Exami that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) -burialphysician a Physician/Medical P.O. Box 68760 attending p as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death ed by the a 1 L Yes 2 L 9 L Unknown g Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Hospital or Attending Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 🕅 No 24a. Was an cate has ; page 2 s autopsy perform 2**/X** N this certific director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No Hospital: Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည within 24 hours after death.

To the Funeral Director; After thi
completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 A Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific D54488 MD

DHMH 17 Hev 7/2009

State Registrar

10

S. Washington St, Easton, MD 21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bennett So, MD, Z19

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Lester Kolb Edward Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Cumberland Western MD Regional Medical Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □XM 2 □ F Months Days Hours (Month, Day, Year) 08/16/1926 Country) Maryland 83 213-22-2765 Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location must be notified at **Funeral Director** Flintstone MD Allegany 1 Yes 2 No 28a-f 10f. Zip Code 10g. Citizen of What Country? ö 10e. Street and Number 21530 23a 13006 Dino Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? 1 🛛 Yes 2 🗌 No 1945-Black, White, etc. 2 þ 1 Never Married 2 X Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 1946 Completed 3 Widowed 4 Divorced White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working ulth and Mental Hygiene. 27 is marked other than "I r traumatic event, the Med life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Esther Dora Lester Kolb Eugene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3515 Mountain Road, Haymarket, VA Department of Health a Important: If item 27 is any injury or other trainonce. Larry Kolb / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Burial 2 X Cremation 3 Removal from State 05/25/2010 Cumberland, MD Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. of Funeral Serv 404 Decatur Street, Cumberland, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ DAJCAC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner contussion nest Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year cate has been signed by the a page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After the completed filled in by the funeral Certificate: After 1 Natural 2 Accident 5 Pending SCOPTER ACCIDENT 10:19 AM 21/10 2 X No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City, or Town, State) determined Koacharay Flintstone, MD Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nerse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and fier 2+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Tuan A Arrisueno, M.D., 12502 Willowbrook Rd, Cumberland, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature 25 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	For State	State of Maryland / D	epartment of H Certificate of D				
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of D		Reg. N	2010	3. Time of Death
	Physicia Medic	n/		ogan-Brown			Month 15	2010	6:39 P M
	Examin		4a. Facility Name (if not institution, give stre		4b. City, Town, or		4	c. County of Death	
_/	·		Frederick Memor	ial Hospital 7. Age (In yrs. last birth		derick If Under 24 Hrs. 8	. Date of Birth	Freder	Dlace (State or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	. o. Elic	rs. Months Days	Hours Min. N	(Month, Day, Year) ov 25, 19	50 Penn	sylvania
	d ow	_ h	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	arylanda-f sh fied a	Director	Maryland Frederick		rsville				1 🏝 Yes 2 🗆 No
	or 28	<u>p</u>	10e. Street and Number		10f. Zip Code	700	10g. C	Citizen of What Cou	ntry?
	s 23a	Funeral	23 E. Pennsylvan			793			
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	۵	11. Marital Status 1 Never Married 2 Mamied 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	13. Was Decedent of His If Yes, specify Cubar 1 Yes 2	, Mexican, Puerto Ric	y Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: B	
5-0	2 hour	plet	15. Decedent's Educa (Specify only highest grade of	completed)	Decedent's Usual Occupa (Give kind of work done do	tion uring most of working	16b.	Kind of Business Ir	ndustry
121	ithin 7 ene. r than	Completed	Elementary/Seconday (0-12) 5+		life. DO NOT use retired) acher		I	Education	
Maryland 21215-0036	l be filed w fental Hygi rked othe tic event,	do l	17. Father's Name (First, Middle, Last) Frank Logan			18. Mother's Name (I Etta Mae	First, Middle, Maidei Raines	n Surname)	
Mary	d 2 should alth and Iv 27 is ma or trauma'		19a. Informant's Name/Relationship (Type, Lawrence Brown	husband 19b.	Mailing Address (Street a	nd Number or Rural F vania Aver	Route Number, City o	or Town, State, Zip ersville,	Code) Maryland 21793
Baltimore,	Page 1 and nent of Hei int: If item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	cemeter	Disposition (Name of y, crematory or other place er Cremator	Da y May 24		Location - City or T derick, M	
Balti	permit. P Departri Importa any inju		21. Sign Jury Funeral Service Licensee	Janu 1	22. Name and Addres	^{s of Facility} Stau umtown Pil	iffer Func ce, Frede	eral Home rick, Mar	yland 21702
	Anysician, Medical Examiner	er	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	toos that caused the death. Do not also on each line. Due to (or as a consequence of the	1 Cano		espiratory arrest,		Approximate Interval Between Onset and Death
_	cate be executed physician and the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	of):		-	1	
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnanc 5 ☐ Other (specify)	у		23d. Date of deli Month	very Day Year
s, P.O.	ires that the signed by	by	Part II. Other significant conditions contr	buting to death but not resulting in	n the underlying cause giv	en in Part i.			the cause of death?
Division of Vital Records,	sician: The law requ certificate has beer rector, page 2 shou	Completed	,				24a. Was an autopsy performed?	prior to c death?	opsy findings available ompletion of cause of
a	ian: Tientifical	Be C	25. Was case referred to medical examiner?			ace of Death (Check o			
Zit.	hysic this ce	은	1 ☐ Yes 2 No Hos	pital: 1 Inpatient 2 ER/Ou 28a. Date of injury 28b. T	itpatient 3 DOA Other	4 U Nursing Hom	e 5 Residence		fy)
n 0	ding F th. After funera	cate	1 Natural 5 Pending 2 Accident Investigation		njury work	? Yes 2 \Bo	ou. Describe now my	ury documed	
ivisio	I or Atten after deat Director:	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	20	Bf. Location (Street a City or Town, Sta		al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2	Medical	(Cheek of Medical Everines	an: To the best of my knowledge, : On the basis of examination and/o	r investigation in my opinic	n, death occurred at t	he time, date and pla	ice, and due to the c	ause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	2	29c. License			Date signed (Month	
			Cup Bul	1 MD	D6	8104	15	12013	010
	6		Eric Bush M	pleted cause of death (Item 23a) (32. Registrar's Signature	Type, Print)	Fred	orick	MDa	21701
	Sta Registr		31. Date filed (Month, Day, Year) NAY 24	20 0 Lessus	A. Janes		·		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		_	State of Maryland / Department of Head 1 - State Registrar Certificate of Dead Certificate of Dead			21		7908
			1. Decedent's Name (First, Middle, Last)		2. Date of Dea	teg. No.	3 Time	of Death
	Physicia		Roland R Loun		Month May	Day	Voor	0 Р м
	Medic Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Loc	cation of Death		4c. County	of Death	
	Examin	٠.	Frederick Memorial Hospital Fre	ederick			Frederick	:
	Funeral		Months Dave U	Under 24 Hrs.	8. Date of Birth	Year)	Birthplace (State Country)	e or Foreign
	Director		215-36-6764 PAIN 2 3 Yrs. Yrs.	A	(Month, Day,	, 1937	Maryland	
7	how at.	<u>_</u>	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside	City Limits
-	aryla la-fs ified	ectc	Maryland Frederick Monrovia				1 🗆 1	Yes X □ No
2	or 28 e not	ä	10e. Street and Number 10f. Zip Code			10g. Citizen of	What Country?	
3	with s 23a ust b	Funeral Director	12506 Fingerboard Road 21770)		U.S	.A.	
4	items items items	Full	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispan If Yes, specify Cuban, M	anic Origin? (Speci Mexican, Puerto Ri	fy Yes or No- ican, etc.)		e - American Indian, ck, White, etc.	
မ္တ	affer (à	1 Never Married 2 Married 1 No 2 No		,		White	
8	ours a atura	Completed by	3 Wildowed 4 Divorced Year or Dates. 1960–62	n			usiness Industry	
15	n "n n "n Medic	ם	(Specify only highest grade completed) (Give kind of work done durin	ng most of working	' [-	
212	within giene er the the l		Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operat	or	1	Scrap	rard	
Maryland 21215-0036	ould be illed within 72 hours after death with the Maryland did Mental Hygiene. Ind Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at.	Be	17. Father's Name (First, Middle, Last) 18.	3. Mother's Name (e)	
<u>a</u>	id be Menta arked artic e	요	Raymond R. Loun	Susie	Cul1	er		
Jar	should be file and Mental I is marked of raumatic eve		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and I					
<u>ა</u>	and 2 lealth im 27 her tr		Barbara Kay Loun - Wife 12506 Fingerbo	· · · · · · · · · · · · · · · · · · ·				
10.	Page 1 and 2 should be nent of Health and Ment ant; If item 27 is market ury or other traumatic e		20a. Method of Disposition 1 Nemoval from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Da			- City or Town, State	1
⊆ 2	permit. Pag Department Important: any injury o		4 Donatho 5 Other (Specify) Providence Cemetery		2010	Kemptow	n, Maryla	nd
Ba	permit. Page Department Important: I any injury o		21. Signature of Funeral Service icenses of Molesworth— 26401 Ridge	-Williams - Road	P.A., Damasc	Funera us, Mar	1 Home yland 20	872
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.				Approxin Interval E Onset an	Between
- P	nysician/ Medical	ř	Immediate Cause (Final disease or condition resulting in death) a. ### AUSTRATORY FAIR Due to (or as a consequence of): ### PROBABLE DESPIRATION	URE			4-5	DAYS
- E	Examiner		Due to (or as a consequence of):	me	100611		4-5	naid
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):	000 501	MOIOI		7-3	0993
pot	ansit	amir	Cause (Disease or injury					
0000	requires triat the cean refittingate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	that initiated events c. Due to (or as a consequence of):					
9 2	nysicia ne bui	dica	d					
687	ing ph	Me	IF FEMALE:					
Box 6	ttend or use	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 1 ☐ Pregnant at time of death 5 ☐ Other (specify)				te of delivery onth Day	Year
B	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown 9 ☐ Unknown		-			
O. 1	ed by detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given i	in Part I.	23e. Did to	bacco use cont	ribute to the cause o	of death?
S, I	sign Id be	Completed by	END STAGE RENAL DISEASE		1 🗆 Y	es 2 🗆 No	3 Probably 4 [Unknown
ord	v requ	olete			24a. Was a		Were autopsy finding	gs available
Sec Sec	te has age 2	luo			autop perfor 1 🗆 Yes	med?	death? 1 🗌 Yes 2 🗎 No	or cause or
	diffication, p	Be C	25. Was case referred to medical 26. Place	of Death (Check of	•	2 140	72700 21170	
	nysical lis cel direc	To E	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other:	4 Nursing Hom	ne 5 🗆 Resid	ence 6 🗍 Oth	er (Specify)	
5 2	fter th	ite:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work?		3d. Describe ho	w injury occurr	ed	į
ion	leath. leath. tor; A the fu	ifice	2 Accident Investigation M 1 Yes	3 2 □ No				
Division of Vital Records,	after of Direction by in by	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	8f. Location (Si City or Town		er or Rural Route Nu	mber,
ם זַּ	to the ropognal or warranty prystorant. The taw requires, within 24 hours after death. To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, dat	ite and place, and	due to the cau	se(s) and mann	er as stated.	- 17
Ī	e Fun e Fun leted	Medical	(Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, donly one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time	death occurred at the	he time, date ar	nd place, and du	e to the cause(s) and	manner stated.
ţ	vithir To th comp	_	29b. Signature and title of certifier 29c. License nur	ımber		29d. Date signe	d (Month, Day, Year)	
			I bellette no 020	6499		5-2	1-10	
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)					
6	TUA		Ronald E. Miller, M.D. #4 Culwell Drive, M 31. Date filed (Month, Day, Year) 32. Registrar's Signature	lount Air	y, Mar	yland	21771	
	Stat Registra	e	MAY 24 2010 Denne J. Sall					
_								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month May Bessie Mae Long Locklear 2010 17, 10:06 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 18412 Garner Lane Accokeek Prince Georges 1929 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, August 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🗶 F Months Hours 80 Director 578-50-9265 Washington, D.C. Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified 1 X Yes 2 No Prince Georges Accokeek Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 hours after death with 18412 Garner Lane 20607 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc δ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify: **Black** Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ntary/Seconday (0-12) College (1-4 or 5+) 12th grade U.S.Department of Army Computer Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental ျ Rache1 Johnson Leon Long 19a. Informant's Name/Relationship (*Type*, *Print***(Daughter)** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 s tof Health a: If item 27 is Shari Locklear Reese Redditt 18412 Garner Lane; Accokeek, Maryland 20607 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) incoln Memorial Cemetery Suitland, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility R. N. Horton Company Morticians, Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Lung Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Exam Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death or in the past 12 months?
1 Yes 2 X No Day Month Year Pregnant at time of death signed by the a d be detached f g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown cate has been signated bage 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N death? 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No Other: ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) hours after death.

neral Director: After this
d filled in by the funeral c 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Funeral L Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) D68503 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1221 Mercantile Lane Piyapong Vøngkovit, M.D. 20774 Largo, Maryland

State Registrar 22. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 19than ぴりゅ 7:00 PM Kwok Luen Lee Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2705 Hardy Avenue Montgomery Wheaton Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Months Days Min. 1 ★ M 2 □ F Feb 24, Day 1949 61 China Director 578-66-0646 Usual Residence of Decedent show filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director MD 1 Yes 2 X No Mon topmery Wheaton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2705 Hardy Avenue 20902 USA or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. the Me Val Examiner Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: Chinese 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use retired) Engineer Technician 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Government Be other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked o Department of Health and Menta Important: If item 27 is marked any injury or other reconstructions. ည Dong Shen Lee Tong How Yuen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patsy S Lee/ Wife 2705 Hardy Avenue, Wheaton, MD 20902 Baltimore, 20a. Method of Disposition Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

washington Natl Cemetery 20c. Location - City or Town, State Date May 24, 2010 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Trancis J. Collins Funeral Home Inc. of Funeral Service License Signature 500 University Blvd W, Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Medical uence of Examiner Ca Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death hed signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy death? 1 Yes 2 No 2 ZNO 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **(X**No မ 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 4 hours after death. uneral Director: After the ed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

hin 24 hours a the Funeral D

State Registrar (Check only one

29b. Signature and title of

Dr. Zhiping Li 720 Rutland Avenue, Baltimore, MD 21205 31. Date filed (Month, L

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

arke

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) May 21, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ames Lucas Day Physician/ Stewart 10:52 8 2010 Mav Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death P.G. Prince Georges Comm. Cheverly Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 7-31-25 1 🗶 M 2 🗆 Months Hours Min Wash. **Director** 84 578-20-0760 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Landover 1 Yes 2 No P.G. MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Kent Village Drive 20785 U.S.A 2201 12. Was Decedent Ever in U.S. Armed Forces? 10/22/ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-13 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 2/3/46 Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fed. Gov't Police Officer 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emma Lucas Roland West 19a. Informant's Name/Relationship (Type, Print) 20735 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5939 Surratts Village Dr. Clinton, Md. Stewart J. Lucas Jr./Son 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/25/10 Triangle, Va. Quantico Nat. Cem 21. Signal of Funeral Service Licens 22. Name and Address of Facility Hackett's Funeral Chapel, Ca W. Nac 814- Upshur Street, NW Part 1. Enter the disease, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final theumonia Physician/ ion disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence for use as the burial-transit that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 2 \ No ed by the a detached f Yes 9 Unknown 9 Unknown P.O. Part II **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Records, or Attending Physician: The law requires 2 № No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate the completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No မ 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5/21/2010 1+ 30. Name and address of person who comple ed cause of death (Item 23a) (Type, Print) Greenway Ctr. Dr. #430 Greenbelt, Md. 20770 TurkeWit MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F			giene	0 17912
			1. Decedent's Name (First, Middle, Las	")				2. Date of Dea Month	ath Day Ye	3. Time of Death
	Physici /Medio		JANE		MUMBRAUER			MAY	20 201	
1	Examir		4a. Facility Name (If not institution, give			4b. City, Town, o	r Location of De	eath	4c. County of E	Death
			Friends Nursing H	ome			Spring		Mont	gomery
	Funeral		Social Security Number 6. Se	x 7. Age □M 2 ⊠ F	(In yrs. last birthday	If Under 1 Year Months Days		in. 8. Date of Birt (Month, Day	h y, Year) 9.	Birthplace (State or Foreign Country)
	Director		490-30-0511	JWI 2381	91 Yrs.			April	5 1919	Missouri
	and will		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Aaryi	5	71 TI		II.4 -1-1	3				1 ☐ Yes 2 No
	the t	rect	Md . Howa	ru	Highlan	10f. Zip Code			10g. Citizen of Wha	t Country?
	with with		6927 Mink Hollow	Road			0777			States
	ns 2	era	11. Marital Status	12. Was Decedent E	ver in U.S. 13.			(Specify Yes or No- lerto Rican, etc.)		American Indian,
(O	or Ite	Fig	1. Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 N	0	47794701		ierto Rican, etc.)		Vhite, etc.
93	al', o	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Madical Examinar must be ricitified at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest grad	ucation		edent's Usual Occup wind of work done		working	16b. Kind of Busin	ess/Industry
2	thin thin	nple	Elementary/Secondary (0-12)	Coflege (1-4or 54	life.	DO NOT use retired	d)	g	_	_
2	ygier th	Co	12	0	A	rtist			Photog	raphy
n d	be fill	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle,		
2	d Mer narke	ဥ	Charles Mumbrau						uermann	
Maryland	12 sh h and 7 is n traun		19a. Informant's Name/Relationship (T Ellen Packard / N					Rural Route Number ad, Highl		00
e,	1 and lealth	1	20a. Method of Disposition		20b. Place of Disp		1100 110	Date	20c. Location - Cit	
Baltimore,	or o		1 ☐ Burial 2 🕱 Cremation 3 🗆		cemetery, cre	matory or other plac	· .			
Ξ̈́	t. Partmer		`4 □ Donation 5 □ Other (Specify			litan Cre		5/21/10		ria, Va.
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 28a-f show amy nijury or other traumatic event, the Medical Examinar must be rediffied at once.		21. Signature of Funeral Service Lion	1/	00470	Muriel H P. O. B	Barbe	r Funeral , Laytons	Home ville, Md	. 20882
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused one cause on each line	the death. Do not er e.	iter the mode of dyir	ng, such as card	diac or respiratory ar	rest,	Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition	. Pneu	monia					Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
	LAGIIIIICI		Sequentially list conditions, if any, leading to immediate	D	iratory F	ailure				
	sit sed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
	cate be executed physician and the burial-transit	хап	that initiated events resulting in death) Last	c. Due to (or as a	consequence of);					
8760,	be ey ician buria	a E		255 10 (01 25 2	. 30/130440/109 31/.					
387	phys the	dlcal		d						
9 X	The law requires that the death certificate be executed tte has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Med	fF FEMALE:	23c. If yes, outcome of	of pregnancy				22d Date 0	f delivery
Вох	atten for u	clan	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 ☐ Fetaf death 3	☐Ectopic pregnancy ☐ Other (specify)	У		23d. Date o Month	Day Year
0	that the death ed by the atte detached for	ysle	1 ☐ Yes 2 🖺 No 9 ☐ Unknown	9□ Unknown	and or double	Other (apochy)				
ص	that the		Part II. Other significant conditions co	entributing to death bu	t not resulting in the	underlying cause giv	en in Part I.	23e. Did to	obacco use contribu	ite to the cause of death?
Records,	w requires that s been signed to should be deta	Completed by	Hypertension					101	Yes 2□No 3[Probably 4 Munknown
00	w req	lete	71					24a. Was	an 24h Wei	re autopsy findings available
Re	he lav	m d						autop perfo	osy prio rmed? dea	r to completion of cause of th?
Vital		o C	25. Was case referred to medical				On Place of F	1 ☐ Yes		Yes 2□ No
Š		To B	examiner?	Hospital: 1 ☐ Inpatier	nt 2 ER/Outpatie	int 3 DOA Oth		Death (Check only only only only only only only only		(Spacific)
o	₽ = E	<u>-</u>	27. Manner of Death	28a. Date of Injury (Month, Day					now infury occurred	Specify
Division	Attending I r death. ector: After by the funer	atlo	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury	M 1 🗆	rk? Yes 2 □ No			
Visi	I or Attendi after death. Director: A I in by the fu	HC	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, farm, s . (Specify)	treet, factory, office				or Rural Route Number,
Ö	in Si fe	Certification;	4 Homicide determined	building, etc.	. (Ѕреспу)			City or Tov	wn, State)	
	To the Hospital or Atten within 24 hours after deat To the Funeral Director; completely filled in by the		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best o	f my knowledge, dea	th occurred at the ti	me, date and pl	ace, and due to the	cause(s) and mann	er as stated.
	he H in 24 he Fi plete	edical	one) Medical Exam	iner: On the basis of and manner stat	examination and/or li	nvestigation, in my c	opinion, death o	ccurred at the time,	date and place, and	due to the cause(s)
	To T To 1	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date signed (/	
•			mul	mu	MI	D 35)/91		may 20	0, 2010
			30. Name and address of person who o					0.17		1 00000
	8		Merlyn K. Vemur					, Silver S	Spring, Mo	1. 20902
	Sta		31. Date filed (Month, Day, Year) 2	32. Registre	r's Signature	1				
	Registi	ar	THE P	- LUIU PRE	num p.	Make				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 8:40 A M James William McPeak May 26 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 16814 Alcott Road Washington Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 31, 9. Birthplace (State or Foreign Months 1**X** M 2□ F Days Hours Min. 63 214-42-1009 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16814 Alcott Road 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? 1968— XXYes 2□No If Yes, Give 1969 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2XXMarried 1969 1∐Yes 2**X∑X**No Specify Specify.White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Retail Office Supplies 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Edward McPeak Frances Almedia Weller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sue E. McPeak - Wife 16814 Alcott Rd. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XX remation 3 ☐ Removal from State 4 ☐ Donation -5
☐Other (Specify) Hagerstown Crematory | 05-27-2010 | Hagerstown, Maryland 21. Signature of Funeral Servi 22. Name and Address of Facility Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due to (or as a consequence of) Sequentially list conditions, Directo for as a nonsequence officause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2000No

Physician /Medical Examiner

permit. Pages 1
Department of I
Important: If ite
any Injury or or
once.

Physician

/Medical

Director

Funeral

ģ

Completed

Be

ဂ

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Madical Evantinar must be notified at

Baltimore, Maryland 21215-0036

and burial-trar attending physician for use as the buria cate has been signed by the page 2 should be detached

The law requires that the death certificate be executed

Box 68760,

P.0.

Division of Vital Records,

Examine Physician/Medical à Completed Be After this funeral dir

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

Certification: To

SH-4

or Attending

Hospital

To the Hospital within 24 hours a To the Funeral C Medical and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Edward Ditto, M.D. 31. Date filed (Month, Day, Year) 32. State

25. Was case referred to medical examiner?

1XXYes 2 □ No

27. Manner of Death

XX Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

111 /1 70 19011 Orchard Terrace Rd.

28a. Date of Injury (Month, Day, Year)

Hospital:

5 ☐ Pending investigation

6 Could not be

MAY 27

29c. License number 10-1061

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and makes obtained to the cause obtained to the cause obtained to the cause obtained to the cause obtained to the cause obtained to the cause obtained to the cause of the cause obtained to the cause obtained to the cause obtained to the cause obtained to the cause obtained to the cause of the cause of the cause of the cause obtained to the cause of the cause of the cause obtained to the cause of

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

14ky 27, 2010

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Hagerstown, MD 21740

1 □ Yes

Other: 4 Nursing Home XX Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

Registrar's Signature

Registrar

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Elmer Mancia 5:08 AM May 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3612 De Pauw Place College Park Prince George's Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Y June 16, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Hours , 1968 215-29-5668 41 Yrs. El Salvador Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's College Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3612 De Pauw Place 20740 El Salvador 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 🔯 No 1 ဩ Yes 2□No Specify: Salvadorian If Yes, Give Year or Dates 3 Divorced 4 Divorced Specify: Hispanic Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bakery 6 Assistant Baker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfredo Alvarez Victoria Mancia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yasmin A. Ventura / Niece 3612 De Pauw Place, College Park, MD 20740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State George Washington Cemetery 5/27/2010 Adelphi, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death disease or condition resulting in death) moni Due to (or as a consequence of) Due to (or as a consequence of): Due to (or as a consequence of): 23d. Date of delivery

Month

29d. Date signed (Month, Day, Year)

21209

2010

25

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 🗌 No

Year

Physician/ Medical Examiner

the burial-trans

as

for use

det

page 2 should be

funeral director,

the

completed filled in by

only one 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MERCIL

W.

2835

32. Registr's Si

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760

Physician/

Medical

10a. State

Examiner

Funeral

Director

28a-f shov

ō

items 23a

ō

ier than "natural", ithe Medical Exan

Il Hygiene.

and Mental F is marked of

traumatic

permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once.

Examiner must be notified at

Director

Funera

þ

Completed

Be

ည

with the Maryland

· death v

within 72 hours after

Baltimore, Maryland 21215-0036

Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? Yes 2 4No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 No ပ 1 Tes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending work? 2 Accident
3 Suicide Investigation 1 Yes 2 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge, and course at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my knowledge, and course at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar SYITH

AVE

29c. License number

BALTIMONE, LID

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryland / Dep Ce	rtificate of Death		1. No.	1910
	1. Decedent's Name (First, Middle, La	ast)		2. Dete of Deeth	Day Va	3. Time of Death
hysician /Medical	Ronald Alp	honzo McNeal, Sr.		Month May 21	Dey 2010 Yes	1755
xaminer	4a Fecility Neme (If not institution, gi	ve street end number)	4b. City, Town, or	Location of Death	4c. County of D	eeth
	Prince George	s Hospital Center		verly		e George's
ral tor		Sex 7. Age (In yrs. last birthday 124 M 2 F 61 Yrs.	If Under 1 Year If Under 24 Hr. Months Deys Hours Mir		(ear) 1948	Birthplace (State or Foreign Country) DC
-	Usuel Residence of Decedent 10a. Stete 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
5						1⊠ Yes 2□ No
acto		George's	Capitol Height		000	
급	10e. Street and Number		10f. Zip Code 20743	100	g. Citizen of What United	
Frai	6804 James Farme			Casait, Van an Na		merican Indian,
Be Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes:	Was Decedent of Hispanic Origin? (If Yes, specify Cuben, Mexican, Pue 1 ☐ Yes 2 ♣ No Specify:	to Rican, etc.)	Black, W	hite, etc.
P P	15. Decedent's E (Specify only highest gr	ducation 16a. Dece	dent's Usuel Occupetion a kind of work done during most of wo	ndkina 16	6b. Kind of Busine	ss/Industry
nple	Elementery/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	~ .	
ő	12th		Landscaper		Priva	te
Be	17. Fether's Name (First, Middle, Last		18. Mother's Na	me (First, Middle, Ma	aiden Surname)	
10	Natha	niel McNeal		Emma Lee		
	19a. Informant's Name/Relationship Delores McNeal/		ing Address (Street and Number or F James Farmer Way	Aural Route Number, o y Capitol	City or Town, State Heights	•, Zip Code) • Md • 20743
	20a. Method of Disposition 1 XSBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	THemoval from State		June 3,	Oc. Location - City	
ے۔	21. Signature of Funeral Service Lice		lar H11 2. Name and Address of Facility S	2010		Maryland
DUCE.	Dohn J. X	1 1	001 Benning Rd. N		ton, DC	20019
ian	23a. Part . Enter the diseese, or com shock, or heart failure. List only			c or respiratory arres	t,	Approximate Interval Between Onset and Death
al er	Immediate Cause (Final disease or condition resulting in death)	a. Emphes	ema			1
ē		Conge Liv		FAIN	p 7	1
듵		0.				1
Examiner	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or es a conse	quence or):			
dical Examin	I triat initiated events	C	ruence off:			1
	resulting in death) Last	Due to (or as a conse	дивлов отј.			
Physician/Me	Part II. Other significant conditions of	contributing to death but not resulting in the	ınderlying cause given in Part t.	23b. Dld tob	acco use contrib	ute to the cause of death?
by Physician				10408	2 □ No 3 □	Probably 4 Unknown
Completed				24a. Was en performe		 Were autopsy findings available prior to completion of cause of death?
E C				1 🗆 Y68	23/No	1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medical		26. Place of De	ath (Check only one))	
To	examiner? 1 ☐ Yes 2 Ž No	Hospital: 1 Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Nursing	Home 5 ☐ Residen	ce 6 □Other (S	Specify)
Certification: 1	27. Menner of Deeth 1 ☑ Neturel 5 ☐ Pending 2 ☐ Accident investigatio	28e. Dete of Injury (Month, Dey Year) 28b. Time of Injury	of 28c. Injury et Work? M 1 Yes 2 No	28d. Describe how	injury occurred	
Ca	L L / tooloom	O 200 Diese of laive. At home form of	root factory office	28f. Location (Stre	et and Number of	Rural Route Number,
Medical Certifi	3 ☐ Suicide 6 ☐ Could not be determined	building, etc. (Specify)	reet, ractory, office	City or Town,	State)	

29d. Date signed (Month, Day, Year)

20785

3001 Hospital Drive Cheverly, Md.

muremil

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

MUKRING St. Registrar's Signature

State Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Nadezhda Month Marti 4:45 PM 2010 05 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater washington Rockville montgome If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 9/24/1924 **Director** Yrs. Russia 219-31-9111 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6105 Montrose Rd 20852 USA 72 hours after death 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 X Widowed 4 Divorced White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 5+ Engineer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ပ Maria "Unknown" <u>Armen Martirosova</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Rabinovich, son 1801 Rockville Pike Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesed Shel Emmes 05/21/2010 Washington, DC 21. Signature of Funeral Se Kurt Blake ²² Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc. MO1477 <u>1170 Rockville Pike Rockville, MD 20852</u> 23ad Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final -Ph sician/ Metastatic cancer (un known disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Advanced Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran signed by the attending physician and defached for use as the burial-trar Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Diabetes mellitus-2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1 Natural □ Accident 5 Pending iniury 1 Yes 2 No Investigation 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) MD D69568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

A. Chilakamarri

31. Date filed (Month, Day, Year)

V&

Rockville, MD 20852

6/21 Montrose Rd

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month HOM AS HERBERI MIL 25 PM Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MON TGOMER MASHINGTON TOTMSYON HOSPITAL IAKOMA PAR If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday) **Funeral** Date of Disc. (Month, Day, Year) 8. Date of Birth 9. Birthplace (State or Foreign 1**₹** M 2 □ F Months Days 215-44-5730 Hours Min. Country) 65 Director strict of Columbi Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Prince Georges Hyattsville 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3818 Oglethorpe Street 20782 USA 12. Was Decedent Ever in U.S. Armed Forces? 1★ Yes 2 □ No If Yes, Give 1965–1971 Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Computer Support 12 |Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Herbert Cornelius Milstead Agnes Susan Hurst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jon T. Wolz / Nephew 17009 Hillard Street, Poolesville, MD 20837 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory Date 20c. Location - City or Town, State 1 Burial 2x Cremation 3 Removal from State May 21, 2010 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of 22. Name and Address of Facility Funeral Home, Inc. Mausa 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ METASTATIC MESO IHELIOMA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir Cause (Disease or linjury that initiated events resulting in death) Last ending physician ar r use as the burial-t Due to (or as a consequence of): Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably M Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? s certificate ha lirector, page 2 1 Yes 2 No 2X No Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificated filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Matural injury 5 Pendina 1 Yes 2 No Accident Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1X_ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 41 aceloo 00069051 2014 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AVE, TAKOMA ATOOD I WASHINGTON ABVENTIST HOSPITAL 209121 BERNICE

Registrar DHMH 17 Rev 7/2009

State

WIREBU

31. Date filed (Month, Day, Year) MAY 24 2010

Baltimore, Maryland 21215-0036

Box 68760

P.0.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year May Chung Kong Tse Ng 11:45 AM Medical 2010 18 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Country) China **Funeral** 8. Date of Birth 1 □ M 2 🖾 F Months Days Hours Min. (Month, Day, Year) Director 266-57-1459 80 Usual Residence of Decedent 28a-f shov items 23a or 28a-f sho ner must be notified at 10c. City. Town or Location 10d. Inside City Limits Directo 1x Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 199 Rollins Ave #534 20852 <u>United States</u> Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or ite Armed Forces?
1 ☐ Yes 2 ☒ No þ 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🏝 No Specify 3 🗆 Widowed 4 🗆 Divorced Specify: Completed Asian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Restaurant Owner Restaurant of Health and Mental Hygie If item 27 is marked other ir other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Pauline Kwok Tse Peter Tse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>John Wu/Spouse</u> MD 20852 Department of Healt Important: If item 2 any injury or other Rollins Ave. Rockville, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Ft. Licoln Crematory 5/25/10 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M01463 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike Rockville, MD 23a. Part 1. Ent. the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he rt failur. List only one cause on each line.

Immediate Cast. [First] Onset and Death Physician/ disease or condition resulting in death) End Stage Parkinsons Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Septicemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certified completed filled in by the funeral director, to 25. Was case referred to medical To Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred I or Attending F after death. 1 🔀 Natural injury 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) 5/18/10 R120698 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Nicole Christenson

24

31. Date filed (Month, Day, Year)

MAY

Registrar's Signature

6001 Muncaster Mill Rd Rockville, MD 20855

		State of Maryland / E	•	artment of I rtificate of			giene Reg. No. 0	0 179	19
		Decedent's Name (First, Middle, Last)				2. Date of Dea	ith	3. Time of	f Death
Physi /Med		Jay Alan O'Brien				Month May	Day 21, 2	Year 010 11:1	.5 A ^M
Exam		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of Death	1	4c. County	of Death	
/		9913 Durango Drive		Damas				gomery	
Funera		5. Social Security Number 216-82-7996 6. Sex 1	thday) Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Year)	Birthplace (State of Country)	or Foreign
Directo	or -	216-82-7996 Survey Surv				Aug. 1	0, 1959	Ohio	
yland how		10a. State 10b. County 10c. City, Town	or Lo	cation		-,		10d. Inside C	ity Limits
e Mar	5	Maryland Montgomery Dama	scu	S				1 □ Yes	2 X No
or 28	Director	10e. Street and Number		10f. Zip Code			10g. Citizen of W	hat Country?	
ath w		9913 Durango Drive		208				.S.A.	
be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Mydical Examinar must be notified at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13.	Was Decedent of if Yes, specify Cul	Hispanic Origin? (S oan, Mexican, Puert	pecify Ye's or No o Rican, etc.)	- 14. Race Black	e - American Indian, k, White, etc.	
irs aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ XYes 2 ☐ No If Yes, Give 2 ☐ No If Yes, Give Year or Dates: 1978-82		1⊡Yes 2 X □No	Specify:		Specify	White	
2 hou				dent's Usual Occu			16b. Kind of Bu	siness/Industry	
thin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life. I	kind of work done DO NOT use retire	during most of wor ed)	king	Air Tr	affic	
ed will ygien er th	5	12	A	ir Contr			Contro		
be file ntal H d oth	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nar	•	Maiden Surnam		
2 should n and Mer is marke raumatic	은	James C. O'Brien				anet M	ontgomer	У	
12 sh th and 7 Is n traun								State, Zip Code) 21	
1 and Health em 27		Melissa O'Brien - Daughter 20a. Method of Disposition 20b. Place o	190 f Disno	1 McGuck esition (Name of matory or other pla	ian Avenu	e - Apt		nnapolis, City or Town, State	Mary1
Pages nent of int: If ite						5/23/10		ria, Virgi	nd a
그 든 뭐 글	zi i	21. Signature of Furneral Service Licensee	22	2. Name and Addr	ess of Facility	3/23/10	ALEXAIIU	ria, virgi	.III.d
Dep	200	tover I L. Hilliamer	M	oleswort 6401 Rid	ess of Facility h-William	s P.A.,	Funeral	Home land 2087	2)
771		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.						Approximat Interval Ber	te
Physician	n	Immediate Cause (Final disease or condition	حز، 1	later	1/12/10	erosis		Onset and	Death
/Medica	al	resulting in death) e. Due to (or a a consequence		100 100	101	C1 5 71			
Examine	■.	Sequentially list conditions, b.							
ed A	ine	cause. Enter Underlying Cause (Disease or injury that initiated events C.							
be executed sician and burial-transit	Examine	that initiated events resulting in death) Last C	of):						
cate be executed oblysician and the burial-transit	dical E	d							
tificate g physi	edie								
eath certifications attending process	N.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death					23d. Dat	e of delivery	
deat he att ed for	Physician/Me	in the past 12 months? 1 Yes 2 No 9 Unknown		☐ Ectopic pregnar ☐ Other (specify)	icy		Mo	nth Day	Year
that the deed by the detached	Phy	9 Unknown							
es be pe	þ	Part II. Other significant conditions contributing to death but not resulting i	n tne u	nderlying cause g	iven in Part I.			ribute to the cause of	
w requir been s should	Completed							3 Probably 4	Olikilowii
has l	ם		_			24a. Was	osv l r	Were autopsy findings prior to completion of o death?	available cause of
ician: The certificate ha							2 🔯 No	I ☐ Yes 2 ☐ No	
sician: certific irector,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗓 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Oi	4 4' -		thor:	ath (Check only o	,		
g Physer this eral dir	1.70	27. Manner of Death 28a. Date of Injury 28b.	Time o	III O D DON	4 LI Nurshig i		dence 6 Oth		
nding lath.	atio	1 X Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	Injury		ork? ⊒Yes 2. □No				
or Attending Physician: after death. Director: After this certific in by the funeral director,	titic	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of Injury - At home, fabuilding, etc. (Specify)	ırm, str	reet, factory, office		28f. Location (City or To	Street and Numb	er or Rural Route Nur	mber,
ital or rs afte ai Dir ed in	Certification:	building, etc. (opecity)				J	, olate/		
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only one) 1							(s)
To the within To the compl	Me			29c. Licer	nse number		29d. Date signe	d (Month, Day, Year)	
		I Steven To Siller		D 00	63195		May 23,	2010	
		30. Name and address of person who completed cause of death (Item 23a)	(Туре,		_ (, _				
OTIVA		Steven D. Wilks, M.D. 6430 Ro	ock.	ledge Dr	Suite	47, Be	thesda,	Maryland	20817
	State strar	31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	back	/				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				Plea	ase Type o	r Print i	n Black I	Indeli	ble In	k. Ens	ure A	All Copie	s Ar	e Leg	ible.				
State of Maryland / Department of Health and Mental Hygiene									1792	0 2									
			Registrar 1. Decedent's Name	- /Finna Adinbut	- /4)		Ce	rtifica	te of L	Death			Reg. No	0.					
	Physicia Medi		Anne R		Oh	Ohlbaum				2. Date of Death May 14, 2010			Year	3. Time of Dea					
9	Examir	ner	4a. Facility Name (if not institution, give street and number 10418 Royal Road				4b. City, Town, or Location of Dea Silver Sprin				in ording of Boulin								
	Funeral Director		5. Social Security No. 093-26-5	250	6. Sex 1 ☐ M 2 ☐ XF				If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. Dec.			8. Date of Bi				lace (State or Fo	oreign		
	yland f show ed at	tor	Usual Residence of 10a. State	Decedent 10b. County		10c.	City, Town or Lo	ocation							1	0d. Inside City Li	imits		
	the Mar or 28a- e notifi	Dire	MD Montgomery 10e. Street and Number				Silver Spring					10a C	itizen of W	hat Coup	1 X Yes 2	□ No			
4	th with ms 23a must b	Funeral Director	10418 Royal Road 20903									U.S.	•						
980	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Farmed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates.				If.		Vas Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Rica ☐ Yes 2 ☑ No Specify:			cify Yes or No Rican, etc.)	fy Yes or No- can, etc.) 14. Ra Bla Specif		- American Indian, , White, etc. White				
21215-0036	n 72 hou an "nat Medica	mple		cify only highe	nt's Education est grade completed	de completed) (Give k		kind of w	dent's Usual Occupation kind of work done during most of workin O NOT use retired)			ing 16b. I		Kind of Business Industry		ustry			
1212	d withir tygiene ther than nt, the	Be Co	Elementary/Seco		_ 5+	College (1-4 or 5+)			cher					Education					
Baltimore, Maryland	ld be file Mental H arked or atic ever	일	17. Father's Name (F		,							(First, Middle renich		Surname)					
Mar	2 shou Ith and 27 is m traum		19a. Informant's Na									l Route Numbe	-			,			
re,	1 and of Hea item		20a. Method of Disp	osition	m/Daughte	20	b. Place of Dispo	osition (Na	me of			Date		ng, I		Land 209	03		
timo	Page tment c tant: If jury or		1 🔀 Burial 2 🛮 4 🔲 Donation			A1	cemetery, crei	Nat	ional	Cem.			Ar1	ingt	on, V	/irginia			
20c. Location of Disposition (Name of cemetery, crematory or other place) 1																			
	nysician/ Medical		23a. Part 1. Enter the shock, or heart Immediate Cause (Findisease or condition resulting in death)	i railure. List d Final	complications that only one cause on ea	ach line.	eath. Do not ent				cardiac o	r respiratory a	rrest,		5	Approximate Interval Between Megants Death	n h		
	Examiner				Due to	(or as a cons	equence of):												
2	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impry that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):																
D	cate be executed physician and the burial-transit	l Exa																	
200	cate be physic s the bu	edica			d										+				
. Box 68760	To the Aospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Directors After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur	hysician/N	ysician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1					eath 3 Ectopic pregnancy 23d. Di			23d. Date Mont	te of delivery onth Day Year						
, P.O.	es that the dea signed by the a be detached f	by Pi	Part II. Other signific	cant conditio	ns contributing to d	eath but not	resulting in the u	underlying	cause give	en in Part I.		I				cause of death?			
ords	v require s been s	Completed by Physician/Medical	leted	leted										1				ably 4 Unknown	
Division of Vital Records,	The law icate has r, page 2 a					autopsy performed? 1 □ Yes 21 No					pri	or to com ath? Yes 2	pletion of cause	of					
/ita	siciar certif irecto	m	25. Was case referred examiner? 1 ☐ Yes 2 🔯		Hospital:				0.11	r:									
of \	ig Phy ter this neral d	te: To	27. Manner of Death		28a. Date	of injury	ER/Outpatier 28b. Time of		OA 28c. Injury	4 ∐ Nur at		ne 5 🔀 Resid 8d. Describe h							
ion	tendir death. tor: Af the fu	Certificate:	1 Natural 5 Pending (Month, Day, Year) injury work? 2 Accident Investigation M 1 Yes 2 No																
Divis	To the Acaptal or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.	al Ceri	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural City or Town, State)																
	he Hosp in 24 hor he Fune pleted fi	Medical	(Uneck 2)	_ Medical E:	Physician: To the b xaminer: On the bas Nurse Practioner:	is of examina	tion and/or invest	tigation in	my opinior	n death occ	urred at t	he time date a	and place	and due to	a tha agua	o(a) and manner	stated.		
			29b. Signature and ti						. License	number			29d. Dat	e signed (/	Month, Da	ay, Year)			
	20	}	30. Name and address	e of per	5 ~ S	e of death //	om 22c) (T 5	Print\		32009)		Мау	18,	2010)			
			Dr. Mich	ael Ba	rth, 1116				venue	#201	, Si	ilver S	prin	ıg, Ma	aryla	and 2090	14		
	Stat Registra	_	31. Date filed (Month,	Day, Year) 2 4 2	010 3º R	egistrar's Sig	ature far	12											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month May 2010 Eloise Elizabeth Poole 5:35 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Yea
Oct. 15, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 👿 F 86 Maryland **Director** 219-14-8435 1923 Usual Residence of Decedent or 28a-f show notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 X No Maryland Carroll Mount Airy 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 4074 Boetler Road 21771 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 Divorced Completed Specify: Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. If item 27 is marked other than ir other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ pe t Charles A. Rippeon Beulah May Molesworth Page 1 and 2 should t 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Mae Poole - Daughter 613 Biggs Avenue, Frederick, Maryland 21702 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ± 5 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Pleasant Hill May 28, 2010 Monrovia, Maryland 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 21. Signature of Funeral Service Dicenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ SEPSIS disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has ara firer death.

aral Director; After this certificate I filled in by the funeral director, pag. performed? 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. injury at 28d. Describe how injury occurred 1 Naturai injury 5 Pending work? Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check

within 24 hours a Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of g 026499 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #4 Culwell Drive, Mount Airy, Maryland 21771 Ronald E. Miller, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

EMELA

DHMH 17 Rev 7/2009

Régistrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Alvin Raynor Pence May 31^{ay} 2010^{ear} 1:35 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Moran Manor Health Care Center Westernport Allegany Age (In yrs. last birthday)
92 Yrs. **Funeral** Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 215-10-8060 1 🔀 M 2 🗆 F Months Days Hours Min March Day 2 Director ₹918 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Allegany MD Westernport Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 262 Wood St. 21562 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1X Yes 2 □ No WW 2 Black, White, etc by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: White rines, Give Year or Dates, Korea Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Paper Manufacturer Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Harry Mary Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Sue Pence/daughter 3966 Forest Valley Rd, Baltimore Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 06/04/2010 Westernport Maryland 4 Donation 5 Other (Specify) Philos Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home a 10 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing indeeth). Due to (or as a consequence of) Exami Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No jo Month Dav signed by the al d be detached fo Year g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harshad Bokil, 566 S. Mineral St, Keyser, WV. 26726 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Thomas Palmore, Jr. 0.5 2010 Medical 0540 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Comm. Hospital Cheverly Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 X M 2 D F Wash. 578-56-4766 Director D.C. Usual Residence of Decedent 28a-f show 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked outber than "natural", or items 23a or 28a-f sho montant: If item 27 is marked outber than "natural", or items 23a or 28a-f sho any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince Georges Upper Marlboro 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10115 Prince Place 20774 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Yes 2 No Yes, Give 1 Yes 2 X No Specify: **Black** 3 Widowed 4 Divorced Completed Year or Dates Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 10 <u>Bus Driver</u> <u>Private Industry</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည John Thomas Palmore, Sr. Mozelle Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10115 Prince Place Upper Marlboro, Maryland 20774 Shirley Palmore (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 05-29-2010 Clinton, MD 22. Name and Address of Facility Ralph Williams, II Funeral Service, P.A. 202PrincetonsDelightDr.; Bowie, MD 20720 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FATAL CARDIAC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami physician and the burial-transit or Attending Physician; The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 Yes 2 L g Unknown signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ၀ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1. 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: Jerfie best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2

Registrar DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DR. MALIKA FAIR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3001

29b. Signature a

HUSPITAL

29c. License number

DR.

29d. Date signed (Month, Day, Year)

10-03840

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gregory Pa	aimer		1- For State Registrar	tate of Maryla		artment o <i>rtificate</i> o		Mental H		2 0 leg. No.	10 17921
Ph Medical E	ysici: xami		Decedent's Name (First, Midd Gregory Charle						2. Date of Dea Month May 19, 2	Day Year	3. Time of Death 1521 hrs
)			4a. Facility Name (if not institution Upper Chesapeake N	on, give street and nur	street and number)			ocation of Deatl		4c. County of	Death
	neral		Social Security Number					If Under 24Hrs		rth(MM/DD/YYYY)	Birthplace (State or
Dire	ector		218–68–5170	1XM 2F	53	Yrs	Months Days	Hours Mir	05/11	/1957	Foreign Country) MD
	any		Usual Residence of Decedent 10a. State 10b. County	·····	10c. City	, Town or Locat	ion				10d. Inside City Limits
yland	-f show	tor	PA 10e. Street and Number		De:	lta ———	Leas				1 Yes 2 X No
the Mar	a or 28, tified a	Director	546 River Road	l			10f. Zip Code 17414		1	Og. Citizen of Wha	at Country?
ath with	or items 23a or 28a-f show any must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 M	12. Was Dece Armed For	dent Ever in U		s Decedent of Hispa es, specify Cuban, I			o- 14. Race - White,	- American Indian, Black, etc.
after de	al", or i	by Fu	3 X Widowed 4 Div	1 Yes	2 X No	1	Yes 2 X No	specify:		Specify: V	White
2 hours.	"natur	ted b	 Decedent's Education (Spe Elementary/Secondary (0-12) 	ecify only highest grade			t's Usual Decupationst of working life. D			16b. Kind of Bus	iness/Industry
0036 within 7	er than Medica	Completed	12		, 0, 0, 1	Copie	Repairm			1	ess Machines
215-C e filed v tal Hygi	ked oth	Be Co	17. Father's Name (First, Middle Milton Palmer,	· _ '				3.Mother's Name Sylvia I		Maiden Surname)	
Baltimore, MD 21215-0036 vermit. Pages I and 2 should be filled within 7 Department of Health and Mental Hysten.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	P	19a. Informant's Name/Relations	ship (Type, Print)			Address (Street a	and Number or I	Rural Route Nur		, State, Zip Code)
e, M I and 2 Health	item 27	ł	Milton Palmer, 20a. Method of Disposition	· · · · · · · · · · · · · · · · · · ·	20b. I	Place of Dispos	nornwood I		Date Date		City or Town, State
imor Pages ment of	or other		1 Burial 2 Cremation 4 Donation 5 Other S				Cremato	_		Odenton	
Balt permit. Depart	Impor		21. Signature of Fundal Service		M01452	Bai	ame and Address of Ley Funer	ral Home	and Cr	remation	Service, PA
Physic /Med		Ť	23a. Part I. Enter the disease, or failure. List only one cause	complications that cau	used the death.	Do not enter the	de mode of dying, su	Lis Road uch as cardiac d	Halet or respiratory arr	est, shock, of hear	TD 21227 Approximate Interval Between Onset and
tam			Immediate Cause (Final disease or condition resulting in death)	a Mixed dr			diazepan	n) & alo	cohol ir	ntoxicati	
		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	onseguence of	f):					
		Medical Examine	cause. Enter Underlying Cause (Disease or injury that initiated					<u> </u>			
ecuted	and - transit	al Ex	events resulting in death) Last	d		· /·					
50, te be ex	ysician burial	Medic	X UNPENDED	23a,27 23c. If yes, ou	,28a-f,	per EM	g904 6/22	2/10 TT		Logi Direct	
687 (certifica	e attending physician and for use as the burial - transit	ian/N	23b. Was decedent pregnant in the past 12 months?	1 Live bin	ilcome of pregi	2 Fe	al death 3	Ectopic pregna	ancy	23d. Date of d Month	Day Year
Box e death	the attered for u	Physician/		known 9 Unknow	m	5 [] Ott	ner (Specify)				
P.O.	deta	ত্র	Part II. Other significant condit	ions contributing to o	death but not re	esulting in the u	nderlying cause give	en in Part I.			ute to the cause of death? Probably 4 Unknown
rds, v require	s been si should b	Completed						1,000	24a, Was autop		ere autopsy findings available for to completion of cause of
Recc The lav	certificate ha	E S						-		rm <u>ed</u> ? de	eath? ✓ Yes 2 No
Vital ysician:	E 호	o Be	25. Was case referred to medica examiner? 1 ✓ Yes 2 No	Hoonitel:	patient 2	ER/Outpatient		Death (Check		Residence 6	Other:
n of J	eral		27. Manner of Death	28a. Date of (Month, D	Injury	28b. Time of Ir	ijury 28c. Injury a	at Work?			d drugs and
/iSiO r Atten	Director: in by the	Certification	Pending Investigation Accident Fd 5/19/10 Fd 1437 hrs Yes 2 No alcohol								or Rural Route Number, City
Div sepital o	filled i	Ser		d not be mined (Specify)	resid	ence			Delta,	tate) 546 Ri PA	or Rural Royte Number, City Ver Rd
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	To the Fu	Medical	(Check only Gottinying i	hysician: To the best of miner: On the basis of	examination ar	ge, death occur nd/or investigati	ed at the time, date on, in my opinion, d	and place, and leath occurred a	due to the caus it the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)
	E 00	Æ	29b. Signature and title of certifie	and manner sta	1		29c. License r				(Month, Day, Year)
		-	30. Name and address of person	who completed cause	of death (Item	, 23a)	O.C.M.	E.		May 20, 201	U
		- 1	Zabiullah Ali M.D.	Assistant Medical	Examiner	111 Peni	Street, Baltim	ore, MD 21	201		
R	Sta egisti	ate	31. Date filed (Month, Day)	0 8 2010 Regi	star's Signatu	re Ø . 🔏	parker				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May Bay 2010 4:20 Рм Angela Marie Raper Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1007 Jousting Way Airy Carrol1 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral 8. Date of Birth (Month, Day, Year) r. 17, 1927 1 M 2 K F Months Hours Director Minnesota 472-22-8235 83 Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b County 10c. City. Town or Location Director 1 🖾 Yes 2 🗆 No Maryland Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1007 Jousting Way 21771 United States hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", 1 ☐ Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Elmer Nelson Lillian Sutherland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles B. Raper / Husband 1007 Jousting Way Mt. Airy, Maryland 21771 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 and Department of F cemetery, crematory or other place 1 🖾 Burial 2 🗌 Cremation 3 🗆 Removal from State May injury 4 ☐ Donation 5 ☐ Other (Specify) 2010 Clarksville, Maryland Columbia Mem Gardens Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 250 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final YNOVIAL set and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-tran Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 XNo 3 ☐ Probably 4 ☐ Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed 1 Yes 2 No 1 Yes 2/ No the Hospital or Attending Physician; nin 24 hours after death.

the Funeral Director; After this certific npleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2/No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5X Residence 6 Other (Specify, 27. Manner of De th 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or inventioning. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 031761

State Registrar 501

MA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

CONNOR

Registrar
DHMH 17 Rev 1/2001

State

Avenie

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ew.12

Year.

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 6–2–10Amend#7PerFHPGCcr Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Carole Anne Rorie 3. Time of Death May 22. Medical 2010 12:37 4a. Facility Name (if not institution, give street and number) Washington Adventist Hospital Examiner 4b. City, Town, or Location of Death Takoma Park 4c. County of Death . Social Security Number 577–56–2963 **Funeral** If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 1 - M 2 XF 9. Birthplace (State or Foreign **Director** 67 Months Days 63-Hours 0'30n2727211943 Country Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exminer must be notified at once. 10a, State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD PG Hyattsville Yes 2 No 10e. Street and Number 10f. Zip Code 4007 Cooper Ln. #B2 Funeral 10g. Citizen of What Country? 20784 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ Black, White, etc. 3 XWidowed 4 ☐ Divorced Completed 1 Yes 2 No Specify: Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Binder Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Robert. Smith Annie Bell Davis 19a. Informant's Name/Relationship (Type, Print) Maurice Rorie/Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6307 63rd Ave. Riverdale, MD 20737 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Riverdale Pk Crematory 5-31-2010 Riverdale, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Ronald Taylor II FH 10583 Middleport Ln. White Plains, MD 20695 Danal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner SEPTICEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit METASTATIC BLON CANCER resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death in the past 12 months?

1 Yes 2 XNo 3 🔲 Ectopic pregnancy 23d. Date of delivery 5 Other (specify) Month Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 23e. Did tobacco use contribute to the cause of death? Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner ပ္ 1 Yes 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide
4 Homicide injury after death filled in by the Investigation 1 Tes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, 24 hours a City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check within 2 29b. Signature and title of certifier whiaka MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DNYEJIAKA 7325A HONEOVER PARKWAY GREENBELT MARYLAND 32. Registrar's Signature MAY 2 0 2010 Registrar Service Con

0	9	-7	0	0	5
1.6		- 1	U.	1	30
U		- 1	- 7	6	

Steven Bennett		1- For State	tate of Maryla		partment c		nd Menta	l Hygiene		201	0 17928
Physici		Registrar 1. Decedent's Name (First, Midd	lle.Last)			Deall		2. Date of	Reg. N	lo.	3. Time of Death
Medical Exami		Month							Da	y Year	1424 hrs
		Steven Benne 4a. Facility Name (if not institution	on, give street and nu		4b. City, Town, or Location of Death				4c. County of D	eath	
		15903 Somerville Drive								Montgome	ry
Funeral		5. Social Security Number	6. Sex	7. Age (In yr	rs. last birthday)	If Under 1 Yea			of Birth (M		Birthplace (State or
Director		216-04-4001	1 X M 2 F	2	6 Yr	Months Day	ys Hours	Min. Aug	. 20	, 1983	oreign Country) Maryland
	1	Usual Residence of Decedent							-		Paryland
v any		10a. State 10b. County			City, Town or Loca						10d. Inside City Limits
and show	5	Maryland Mont	gomery	G	aithersb	urg					1 X Yes 2 No
Maryl 28a-1	rector	10e. Street and Number		10f. Zip Code 10g					Country?		
ith the Maryland 23a or 28a-f show notified at once.	ۃ	805 Pointer Ri		20878			U	SA			
h with	uneral	11. Marital Status	12. Was Dec			as Decedent of Hi					merican Indian, Black,
deati or ite	Fun	1 Never Married 2 M	1 Yes	2 X No		es, specify Cuba	n, Mexican, Pt	ieno Rican, etc.)	White, et	С.
after	ģ		orced If Yes, Give Year or Dates:		1	_ LA				Specify: W]	hite
hours		15. Decedent's Education (Spe				nt's Usual Occupa nost of working life				Kind of Busine	ess/Industry ureau, Dept.
36 n 72 n 72 lical	olet	Elementary/Secondary (0-12)	,	-4 or 5+)				, , , , ,		f Comme:	
withi withi giene.	Completed	47 Falls and Name (First Miles)	4		Stati	stician					
15-1 filed I Hyg ed oth		17. Father's Name (First, Middle, Denis Eugene R						lame (First, Mid Marie H			
21215-0036 uild be filed within 7 Mental Hygiene. marked other than ic event, the Medica	o Be	19a. Informant's Name/Relations	thin (Type Print)		19h Mailin	g Address (Stree	at and Niverba	on Dural Davis	Microslana	City as Town C	1-1- 7:- C-1-)
MD 2 d 2 shou lth and N n 27 is n	리	Jane H. Rumbau		ar							
and 2 lealth	H	20a. Method of Disposition	gii / Mocife		b. Place of Dispos			Drive,			g, MD 20878 or Town, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 X Cremation	1 3 Removal fro	m State	crematory or ot	her place)	. 1	May 26, 2010			
timent		4 Donation 5 Other Sp		IV.	etropolita		l.				, Virginia
Ball Separ mpon	- 1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc.								nc.	
	j	23a Part I Enter the disease or	grevace	viced the de-	50	ouniver	SICY B	Iva., w	., 5:	liver Sp	oring, and 20901
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and									
Examiner		Immediate Cause (Final disease or condition resulting in death)									Death
		bus to (or as a consequence or),									
	<u>a</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ulboase or injury that imitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
	딑										
B 8 8	Ä										
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	dical	LINDENDED	d							= .	
O, e be e rsiciau burial	ğ	UNPENDED	AMENDED								
Box 6876C e death certificate the attending physe ed for use as the b		IF FEMALE: 23b. Was decedent pregnant in th	23c. If yes, o			tal death 3	Ectopic pre	ananau	2	3d. Date of deliv	
K 68	Si	past 12 months?		ant at time of	death	tal death 3 her (Specify)	Ectopic pre	griancy		Month	Day Year
BOy death death	ysi	1 Yes 2 No 9 Unk	known 9 Unknow	wn	٥ ٥١	lier (openity)			- 1		
at the		Part II. Other significant conditi	ons contributing to	death but no	ot resulting in the u	inderlying cause g	given in Part I.	23e. D	id tobacc	o use contribute	to the cause of death?
signe be de	d b							1	Yes 2	✓ No 3 P	Probably 4 Unknown
rds requi	ete								/as an		autopsy findings available
e law e has ge 2 s	Completed							p	utopsy erform <u>ed?</u>	death	
Division of Vital Records, P.O. Boy tal or Attending Physician: The law requires that the death is after death. al Director: After this certificate has been signed by the att led in by the funeral director, page 2 should be detached for		25. Was case referred to medical				00 DI	-f D11: (O):		es 2	No 1 ✓	Yes 2 No
ician sician s cert irecto	ď	examiner?	Hospital:	patient 2	ER/Outpatient		of Death (Che	rsing Home 5	D. Davis	lence 6 🗸 Ot	h 0
Phys Phys	라	1 Yes 2 No 27. Manner of Death									ner. Scene
n of Iding Pl th. : After	<u>ë</u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject jumped from 7th floor of p							or of parking garage		
ivision I or Attend after death. Director: d in by the f	Certification:	Accident Accide								David David No. 10%	
Divi	뜀	deter	d not be		nome, tarm, stree	et, factory, office b	uilding, etc.	or Tow	n, State)		
hou fil		4 Homicide	(Opociny)				_	_1		Orive , Rockvil	
he Ho in 24 he Fu	ca	(Check only	nysician: To the best miner:On the basis of								
P. Mith	BL	29b. Signature and title of certifie	and manner sta	ated.	. ariai or introdugat	29c. License		od at the thine, a			
100	-	29b. organization and the organization									Month, Day, Year)
1	L	0-102	_ ~			O.C.I	VI. C.		IVIA	y 15, 2010	
		30. Name and address of person	·			Donn Ctract	Daltimas	MD 04004			
Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltim State 31. Date filed (Month, Day Year) 42. Registrar's Signature							Baitimore,	IVID 21201			
Sta Regist	400	31. Date filed (Month, Day Year)	110 Sz. Reg	Jistrar's Sign	ture park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** /Medical :56 4 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Davs | Hours | Min. . Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) Days N/A Director 9 09/01/2000 GUATEMALA Usual Residence of Decedent the Maryland 10a State or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits be notifled at Director MD TALBOT 1 Yes 2 X No ROYAL OAK 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 23a 25925 ACORN ROAD must t Funeral 21662 **GUATEMALA** 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: Maryland 21215-0036 5 2X No þ 1 🛣 Yes 2 🗆 No Specify: GUATEMALAN 3 Widowed 4 Divorced Specify: HISPANIC "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) 0 N/A other N/A 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi es 1 and 2 should be of Health and Mental | GAMALIEL SANCHEZ 2 GLADIS HERRERA traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GAMALIEL SANCHEZ/FATHER PO BOX 453 ROYAL OAK, MD 21662 Baltimore. 20a. Method of Disposition Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date ŏ Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State HUEHUETENANGO 4 Donation 5 Other (Specify) CASERIO JALAPA 06/15/2010 GUATEMALA 21. Signature Funeral Service Icenses Name and Address of Facility
ELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
00 SOUTH HARRISON ST., EASTON, MD 21601 art 1. Enter the disea shock, or heart failure e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition Se OSI3 /Medical dar resulting in death) Due to (or as a consequence of) Examiner Preumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine or Attending Physician: The law requires that the death certificate be executed Herlens Due to (or as a consequence burial Division of Vital Records, P.O. Box 68760, cian Physician/Medical the SS IF FEMALE use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death in the past 12 months? 3 - Ectopic pregnancy Pregnant at time of death Month Day Year 2 No 5 Other (specify) detached the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 23e. Did tobacco use contribute to the cause of death? should be Completed 2 No 3 Probably 4 Unknown 1 Yes been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed? certificate 1 🗌 Yes 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 4 \sum Nursing Home မှ 1_Inpatient 2 ER/Outpatient 3 DOA After this 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 2 Accident in by the 1 🗌 Yes 2 No Director: 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) the Hospital the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 24 one) and manner stated 29b. Signature and title of certific ည 29c. License number 29d. Date signed (Month, Day, Year) 80. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0S1 OME 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month State

Registrar

DHMH 17 Rev 1/2001

Jack.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 4:20 MAY 010 MICHAEL GTLMORE STRIPPEY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs. Social Security Number Age (In vrs. last birthday 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 XM 2 - F Maryland Months Hours 02/11/1960 Director 217-76-9587 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: In item 25 is marked of other than "natural", or items 25 or 28a-f sho and injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4743 Old Middletown Road 21755 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian Armed Forces Completed by Black, White, etc. 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 - Widowed 4 - Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Director of Mainteniance Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Eugene Strippey Bonnie Swisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Strippey (spouse) 4743 Old Middletown Rd. Jefferson, MD 21755 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Sperry's Run Cemetery 05/26/2010 Rio, West Virginia 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike Frederick, MD 21702 36a. Part 1. Enjoy the disease, or complicate shock, or heart failure. List only one can caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** tas cancer Sequentially list conditions, if any local solutions of the cause. Enter Underlying Cause (Disease or linjury that initiated events Examil To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2. No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No Certificate: To 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practicinars To the basis of my incomes due to our addation in a date and place, and the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 2010 MDD 35106

State Registrar 32. Registrar's Signature

7th Street Frederick, Maryland 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myung Hee Nam

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year Lee Scottlin SNYDER May 27, 7:20 a. M 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1211 Peppercorn Drive Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
March 29,1928 Birthplace (State or Foreign Country) **Funeral** Months Days Min. 1 🖾 M 2 🗆 F Hours 82 213-24-8347 **Director** Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examinar must be notified at 1 ☐ Yes 2 No Maryland Funeral Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1211 Peppercorn Drive 21740 USA Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: \$ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygienn Important: If Item 27 Is marked other the any injury or other traumatic event, Ins. once. grinder sand blasting mfg. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bruce N. Snyder Lucy T. Blake ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Louise Snyder - wife 1211 Peppercorn Dr., Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. View Cemetery 6/2/10 Sharpsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due lo (or as a conseque ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence o Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician a P.O. Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 3d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has l page 2 s certificate 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 512 Residence 6 Other (Specify) Certification: To in 24 hours are the funeral Director: After this and the Funeral Director and the funeral direct 1 Yes 2 DN 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 1 D Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-5 81 820 31. Date filed (Month, Day, Year) State MAY 27

Registrar

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02/76/5070 10:43 AM Josephine Sullivan Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince Georges 48ll Emo St. Capitol Heights 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Hours OL 2013 21 448 Director GA <u>578-66-8447</u> Usual Residence of Decedent 10a. State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Capitol Heights MD Prince Georges 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **NZA** 20743 4811 Emo St. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian þ 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed **Black** Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Caregiver Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Katherine Thomas Ben Henry Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carlton C. Sullivan/husband 4811 Emo St., Capitol Heights, MD 20743 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Washington Nat'l Cem; 05/22-2010 Suitland, MD 4 Dentation 5 Other (Specify) ^{22. Name and Address of Facility} Strickland Funeral Services L500 Allentown Rd., Camp Springs, MD 20748 Sign ture f Funeral S Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final un Physician/ 01 Medical resulting in death) Due to (or as a consequence of) Examiner 27 months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det ģ 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform certificate 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 2 No 1 Inpatient 2 ER/Outpatient 3 DOA after death.

Director: After this Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide (Month, Day, Year) work?
1 Yes 2 No 5 Pending Investigation 6 Could not be filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practiceur: To the best of my houldedge death or id at the time, date and place, and due to the re-29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 120068057 pleted cause of death (Item 23a) (Type, Print) 1221 Hercantile 31. Date filed (Month, Day

DHMH 17 Rev 7/2009

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

٠		•	For State Registrar	State of Ivial year		rtificate d			Reg. No. 0 0	17933	
	Physicia	an	1. Decedent's Name (First, Middle, Las	•		0	T	2. Date of Dea Month	Dav Year	3. Time of Death	
1	/Medic		Robert	Kendall	, i	Smith,		May 23	, 2010	2:45 A M	
	Examin	er	4a. Facility Name (If not institution, give Lions Center for		Cano		n, or Location of Death umberland	1	Allegany		
	Funeral Director		Social Security Number 6. S			If Under 1 Ye Months Da	ar If Under 24 Hrs.	8. Date of Birth (Month, Day 08/18/	n 9. Bir	thplace (State or Foreign ountry) ryland	
	pu »		Usual Residence of Decedent	100 0	ity, Town or Lo	nation				10d. Inside City Limits	
	laryla shov	ō	10a. State 10b. County Allega			Cumberl	and			1 ☑ Yes 2 ☐ No	
	the N 28a-1	Director	10e. Street and Number	,		10f. Zip Cod		1	10g. Citizen of What C	ountry?	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, I've Medical Examination must be notified at once.		209 Central	Avenue			21502		USA		
	r deat	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13.	Was Decedent If Yes, specify (of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.		
36	s afte	y F	1 X Never Married 2 Married 3 Widowed 4 Divorced	il tes, dive	62-	1⊡Yes 2∏X			Specify:	White	
9	2 hour	Completed by	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Oc			16b. Kind of Business	/Industry	
215	thin 7; re. ran "n	nple	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	(Give life.	kind of work do DO NOT use re	one during most of wor tired)	king			
21	led wi tygier her th	S	12	5	Cor	rectio	nal Office		State Maiden Surname)	of Maryland	
anc	d be fill be f	Be c	17. Father's Name (First, Middle, Last) Robert	Kendall	Smith	. Sr.	Mary	ne (<i>First, Middle,</i> Ru		icker	
Maryland 21215-0036	should and Me mark	ဥ	19a. Informant's Name/Relationship (7	ype. Print)		-	reet and Number or Ru	ıral Route Numbe	er, City or Town, State,	Zip Code)	
ž	and 2 valth a		Barbara J. Himes	/ Friend	302	2 Park	Street, Cu	mberland	, MD 2150	2	
Baltimore,	es 1 and Hes 1 a		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐	20b.	Place of Dispo cemetery, crea	osition (Name o matory or other	f place)	Date	20c. Location - City or	Town, State	
Ē	t. Pag tment tant: jury o		4 ☐ Bonation 5 ☐ Other (Specify) / Cui			atory 05/2		Cumberla		
Bai	permii Depar Impor any In		21. Sur atule of Funeral Survice Linux	land					ily Funera rland, MD	1 Home, P.A. 21502	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the dea	th. Do not en	ter the mode of	A .		rest,	Approximate Interval Between Onset and Death	
4	Physician		Immediate Cause (Final disease or condition resulting in death)	a Cerebro		lan	Acciden	<u> </u>		3 Weeks	
	/Medical Examiner	М	rooding in dodiny	Due to (or as a consec	quence of):						
		Jer	Sequentially list conditions, if any leading to immediate cause. Enter Underlying	b. Due to (or as a consec	quence of):						
	scuted nd ransit	Examiner	that initiated events	C							
90,	be execian a		resulting in death) Last	Due to (or as a consec	quence of):						
68760,	rtificate be executed ng physician and as the burial-transit	Jedical		d							
×	£ 5, 6	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregr					23d. Date of de	elivery	
P.O. Box	at the death cert I by the attending stached for use a	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		☐ Ectopic pregr ☐ Other (specif			Month	Day Year	
<u>Ч</u>	that the ned by th detache	Phys	g Unknown		and the second second		ation to Book I	20e Did to	bbacco use contribute	to the course of death?	
ds,	signe signe d be d	þ	Part II. Other significant conditions co	ontributing to death but not re	sulang in the u	indenying cause	given in Part I.			Probably 4 Onknown	
Records,	w requires s been signi should be	Completed						24a. Was a	an 24h Were a	utopsy findings available	
Be	: The law cate has pege 2 s	шо						autop perfor	sy prior to rmed? death?	completion of cause of	
ţ	siclan: Th certificate rector, peg	BeC	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only or		s 2 110	
<u>></u>	Physic this ce		I les 214/10	Hospital: 1 ☐ Inpatient 2 ☐			Other: 4 X Nursing H	lome 5 ☐ Resid	lence 6 ☐ Other (Sp	ecify)	
28d. Describe now injury occurred long. (Month, Day, Year)											
S	I or Attenc after death Director: I in by the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome, farm, sti			28f. Location (S	Street and Number or F	Rural Route Number.	
2	al or / s after I Dire	erti	4 ☐ Homicide determined	building, etc. (Spec	ify)			City or Tow	vn, State)		
	To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical (29a. Certifier 1 Certifying Ph	ysician: To the best of my kniner: On the basis of examinant	owledge, deal	th occurred at the	ne time, date and plac my opinion, death occ	e, and due to the urred at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)	
	omple	Mec	29b. Signature and title of certifier	amplianner stated.		29c. Lie	cense number		29d. Date signed (Mor	oth, Day, Year)	
	5+			Morler	_	D3	3280		May 24,	2010	
	nRS		30. Name and address of person who of Sunil K. Gup				, Cumberla	nd MD	21502		
	Sta	te.	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature.		, cumberta	uid, PiD			
	Sta		MAY 25 2010	h A	Joans.	1					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5/20/2010 10:30 AM Harvey L. Sega1 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🛣 M 2 🗆 F Months Days Hours Director 6/19/1925 New York 84 092-18-6378 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at Director 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits 1 X Yes 2 No Md Montgomery Potomac o. 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral filed within 72 hours after death with 10714 Potomac Tennis Lane 20854 12. Was Decedent Ever in U.S.
Armed Forces? 6/1944
1 Xes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married þ altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3X Widowed 4 ☐ Divorced Specify. White 8/1946 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) I Hygiene. Civil Engineer <u>Pentagon / Air Force</u> Be permit. Page 1 and 2 should be file Department of Health and Mental H Important; If item 27 is marked oth any injury or other traumations. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Ethel Leopold Jacob Segal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Brother Philip Segal 1588 Hereford Rd Hewlett, NY 11557 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gaedens 5/23/2010 Olney, Md Signatur of Fureral Service Licensee 22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death week Physician/ disease or condition Pneumonia Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Obstructive Pulmonary Disease few years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) ttending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Day Year 7 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ leted 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 0 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ₹ Sed performed? Yes 2 No 1 Yes 2 No C ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2X No No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ಹ D37891 S May 20, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A Rajvanshi 121 Congressional Lane # 409 Rockville, Md 20852 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar MEND#10c, e, f, per INF, 5/28/10/BW, McCo
Registrar MEND#2+26perMD, 5/28/10, BW, McCo
Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Jean B. Shamanski May 10 2010 10:42 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5200 Myer Court Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Days Hours July 17, Pay Year 1939 185-30-3291 70 Yrs Director Usual Residence of Decedent show 10b. County Examiner must be notified at 10a. State 10c. City, Town or Location Silver Spring 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Montgomery Rockwillo 10e. Street and Number 12324 Judson Road ō 10f. Zip Code 20906 10g. Citizen of What Country? 23a Funeral 5200 Myer USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. ö þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Specify: White "natural", Completed 3 XWidowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene, Elementary/Seconday (0-12) College (1-4 or 5+) the Payroll Manager Engineering Be Department of Health and Mental Himportant: If item 27 is marked ott any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Joseph Lucas permit. Page 1 and 2 should be Thelma Bianchini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5200 Myer Court, Rockville, MD 20853 Fay L. Shamanski/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Gate of Heaven Cemetery Ma X 25 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Spring, MD 20901 23a. Part 1. Enter the disease, or complications that careed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Hepatocellular Carcinoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? daughter's Hospital 2 XNo Other: ၉ 1 🗌 Yes 4 Nursing Home 5 Residence 6 X Other (Specifices idence 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Tyes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 21, 2010

DHMH 17 Rev 7/2009

State

Registrar

MA

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steve Wilks, MD

24 2010

31. Date filed (Month, Day, Year)

00063195

8600 Old Georgetown Road, Bethesda, MD 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 19, 2010 Year 9:04 ам James Sims Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 **X** M 2 □ F Months Hours ^{htry)}Alabama Director 420-36-<u>49</u>82 Usual Residence of Decedent ral", or items 23a or 28a-f sho Examiner must be notifled at 10b. County be filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Huattsville Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2107 Woodberry Street 20782 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑ Yes 2 ☐ No Konea
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify 3 Widowed 4 Divorced Year or Dates. Vietnam Black if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Serviceman U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Otis Sims Lu Elle Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sun-Cha Sims - Spouse Page 1 and 2 2107 Woodberry Street, Takoma Park, Maryland 20912 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit, Page 1 a Department of H Important: If ite any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Arlington Natl. Cem. | 06/22/2010 | Arlington, Virginia 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Ringle Funeral Home. Inc. neMari-11800 New Hampshiree Ave., Silver Spring, MD 2090# 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ asou disease or condition resulting in death) Medical Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the 74 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and benneled lifted in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 PER/Outpatient 3 I DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar Randolph Rd #216. ROCKNILL, MD 20852

who completed cause of death (Item 23a) (Type, Print)

Day, Year) 9 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2150 Erika Dana Smith May 20. 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min. Washington. 09/16/1971 216-88-1701 **Director** Yrs. Usual Residence of Decedent 10a, State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director Silver Spring 1 Yes 2 X No Maruland Montgomery 10e, Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 15712 Pamela Drive u.s.A. 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 X Never Married 2 Married Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify: African-American Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working should be filed within 72 and Mental Hygiene. Maryland Department Elementary/Seconday (0-12) College (1-4 or 5+) of Corrections Pre Trial Counselor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Laurel T. Travers Gerald L. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Laurel T. Smith - Mother 15712 Pamela Drive, Silver Spring, Maryland 20905 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 🛛 Cremation 3 🗋 Removal from State Lincoln Crematory 05/28/2010 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 111800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death
4 months Physician/ Respiratory Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Metastatic Breast Cancer 3½ Years Sequentially list conditions, Examine cause. Enter Underlying
Cause (Disease or linjury Dubito (or as a consequence of). requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🗶 No ò Pregnant at time of death Month Day Year 1 Yes 2 2 9 Unknown signed by the a d be detached f 9 Unknown Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Breast Cancer - 11 years 1 ☐ Yes 2 🕅 No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 Yes 2 No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No ၉ 1 🗌 Yes 1 X Inpatient 2 ER/Outpatient 3 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Box 68760 P.O. Records, Hospital or Attending Physician; The law Division of Vital filled in by 24 hours Funeral completed within 2

Maryland 21215-0036

29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

D35996

May 21, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Linda M. Burrell, MD, 2730 University Blvd.. #400, Wheaton, Maryland 20902

State Registrar

31. Date filed (Month, Day, Year) 24

è

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Nancy Edwina Tansill 1:27 P M May 20, 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death WMHS-Frostburg Nursing& Rehab Center Frostburg Allegany If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 540-50-6035 66 10/15/1943 Oregon Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 TYes 2 No MD Allegany Cumberland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 104 Wills Creek Avenue 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🎇 No Specify Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 <u>Homemaker</u> Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Floyd Shaff Mona Betty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Anna M. Laber / Daughter 106 Wills Creek Avenue, Cumberland, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State Cumberland Crematory 05/21/2010 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final Acute Cerebrovascular Accident disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one)

Physician /Medical Examiner

Attending Physician: The law requires that the death certificate be executed

Division of Vital Records. P.O. Box 68760.

certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran

funeral director,

After this

.cal or Att.
tours after death.

*al Director: Att.
in by the fire

To the Hospital within 24 hours a To the Funeral (completely filled Hospital

5

nder

permit. Page Department of Important: If any Injury or once.

Physician

Examiner

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Ergin nor must be notified at

Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23 uny or other traumatic event, I'm. "Actual Extra mercular uny or other traumatic event, I'm."

Baltimore, Maryland 21215-0036

the Maryland

with

/Medical

Director

Funeral

Þ

Completed

Be

၉

Examine

Physician/Medical

3

Completed

Be

Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner? 1∐Yes 2XINo

27. Manner of Death 5 Pending 2 Accident investigation

6 ☐ Could not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

To certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

1 🛛 Naturai

3 Suicide

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D26907

29d. Date signed (Month, Day, Year) May 20, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Harjit S. Sidhu, M.D., 925 Bishop Walsh Road, Cumberland, MD 32. Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Joella D. Vaughan 4:30 May 23, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Washington Julia Manor Health Care Center Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Months Hours Knoxville. 578-22-6611 86 **Director** tober Usual Residence of Decedent , or items 23a or 28a-f shov 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director West Berkeley Hedgesville 1 Yes 2 No Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 25427 USA 292 Amethyst Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give "natural", Specify: White 3 ☒ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. the Me Elementary/Seconday (0-12) College (1-4 or 5+) Union Trust Bank Supervisor Bank by Mail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Bryan Dowling Jemima Kate Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerilyn S. Rock / Daughter 292 Amethyst Lane, Hedgesville, WV 25427 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 5/28/2010 Suitland, Maryland 4 Donation 5 Other (Specify) Cedar Hill Cemetery Signature of Funeral Service Licenses 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA RAY Rogers Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 541ac Medical resulting in death) a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician; The law requires that the death certificate be Box 68760 the attending p IF FEMALE . If yes, outcome of pregnancy 1 D Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 🖒 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? **2**√2 No 1 Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? 힏 2 X No 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) funeral Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital or within 24 hours at To the Funeral D completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17:Riw 7/2009

State Registrar nuil street Hagestam

f death (Item 23a) (Type, Print)

368

of person who completed cause

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ James R. Williams Month 20, 2010a 5:00 A M May Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Frederick Braddock Heights 7103 Ridge Road Social Security Number 220-10-5409 If Under 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 □ F Months Hours April II. Director Maryland 1922 88 Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Ves 2 No Braddock Heights Marvland Frederick ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or Funeral 21714 United States 7103 Ridge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 X Yes 2 No 1943-Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates. 1 Yes 2 X No Specify. 3 ∰Widowed 4 ☐ Divorced Specify Completed 1946 the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) Coilege (1-4 or 5+) Purchasing Agent US Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) marked 2 Conrad H. Williams Alma V. Mercer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S 27 Sylvia Lucas / Daughter 6995 Alabaster Court, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5 1 Surial 2 Cremation 3 Removal from State 5/22/2010 4 Donation 5 Other (Specify) Middletown Lutheran Middletown, Maryland Signature of Fundal Service Lic Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ COVER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): -transit death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last burial-Completed by Physician/Medical Box 68760 attending phase as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes should peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? certificate Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 000 Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARAKAT 310 W. 32. Registrar's Signature State Registrar Had Belook

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

		ŀ	For State Registrar	State of Ma	-	epartment of F Ce <i>rtificate of L</i>		and ivi		gierie Reg. No.	2010	794	
	Physicia	n/	1. Decedent's Name (First, Middle, Las	t)					2. Date of Dea Month	Day	Year	3. Time of Death	
	Medic	al	Luther Watkins 4a. Facility Name (if not institution, give			4b. City, Town, or	Location		May	20	2010 County of Death	5:45a ^M	
	Examin	er	8419 Water Street			2179		OI DOUGII		Frederick			
	Funeral		5. Social Security Number 6. Se	X 7. Age	(In yrs. last birth	day) If Under 1 Year Months Days	If Under Hours	Min	8. Date of Birth (Month, Day	(Vear)	g. Birth	nplace (State or Foreign ntry) 1ahoma	
	Director		440-28-0389 Usual Residence of Decedent	111 2 2 1	83 Y	rs.			March I	<u>6,19</u>	27 Ok	Lahoma	
	land show dat	tor	10a. State 10b. County		10c. City, Town	or Location				-		10d. Inside City Limits	
	e Mary 28a-1 notifie	irec	Maryland Freder	ick	<u>Walkers</u>	ville 10f. Zip Code				10. 0%		1 Yes 2 X No	
	rith the 23a or st be r	ral	10e. Street and Number	D 1		21.79	2				ng. Citizen of What Country? United States		
	eath w	Funeral Director	8419 Water Street 11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. Was Decedent of H	ispanic Or	igin? (Spec	cify Yes or No-		4. Race - Ameri	ican Indian,	
36	after d ", or i kamin	ò	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 1 N		1 ☐ Yes 2 🛣 No			ilican, cio.,	s	Black, White		
8	nours a	Completed	3 Wildowed 4 Divorced Year or Dates. WWII Wh 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Busines							White and of Business In			
215	iin 72 l ie. han "r e Med	dwo	(Specify only highest gra	de completed) College (1-4 or 5+		Give kind of work done of the control of the contro	-	st of workin	g				
2	d with ther ther ther ther ther there	BeC	17. Father's Name (First, Middle, Last)			Brick Mas		ner's Name	(First, Middle, i	Maiden S	Masonry	У	
auc	be file ental h rked o ic eve	2	Fate Watkins						ement		arriarrey		
ary	should and M is mai		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b.	Mailing Address (Street	and Numb	er or Rural	Route Number	; City or T	Town, State, Zip	Code)	
∑ o`	I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show item 27 is marked other than "natural", or items 25a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Ruby Watkins/ Wife	<u> </u>		9 Water St					lle, Mary	yland 21793	
10re	Page 1 and ment of Hea ant: If item ury or other		1	Removal from State	cemetery	, crematory or other plac			4,2010		•	Maryland	
Baltimore, Maryland 21215-0036	permit. Page 1 Department of I Important: If it any injury or o		21. Signature of F Ineral Service Licens		Kestnav	ven Memoria 22 Name and Addre							
č	Der Im B		> Degu	*							ick,Mar	yland 21702	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	olications that caused ne cause on each line.	the death. Do no	ot enter the mode of dyir	ig, such as	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death	
- 1	Pnysician/ ≀ Medical		Immediate Cause (Final disease or condition resulting in death)		chic Pul	monary Fibi	cosis					5 Years	
	Examiner			Due to (or as a	consequence of	y.							
	_ +	iner	Sequentially list conditions, if any, leading to immediate cause. Enter once lying	Due to (or as a	consequence of	η:							
	ecutec and -transi	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a	consequence of	η:							
0	icate be executed physician and s the burial-transit	edical I		d									
Box 68760	tificate ng phy as the	Med	IF FEMALE:	7.5				111		- 1	,		
9 ×	ath certific attending	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of Live Birth 2 Pregnant at	2 Fetal death	3 Ectopic pregnant	су			2	23d. Date of deli Month	ivery Day Year	
	ne dea y the a ched f	hysic	1 Yes 2 No 9 Unknown	9 Unknown	time of death	5 🗆 Other (specify)							
<u>о</u>	that the need by e deta	by P	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	the underlying cause gi	ven in Par	t 1.	0			the cause of death?	
ġ,	requires that the de been signed by the should be detached	ted										obably 4 🗆 Unknown	
Division of Vital Records, P.O.	has be	Completed		·			_		24a. Was autop		prior to c death?	opsy findings available completion of cause of	
ž	sician: The la certificate ha irector, page?		25. Was case referred to medical			26. P	lace of De	ath (Check	1 Tyes	2 🔀 No	1 🗆 Yes	2 🔣 No	
Vita	Physician: this certificaral director, p	To Be	examiner? 1 Yes 2 No	Hospital: 1 🗌 Inpatie	ent 2 ☐ ER/Out	patient 3 DOA Oth	or.			dence 6	Other (Speci	ify)	
o t	ing Ph		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injur (Month, Day)		jury wor	k?		28d. Describe h	ow injury	occurred	:	
sior	death ctor: A	Certificate:	2 Accident Investigation 3 Suicide 6 Could not b		ry - At home, far	M 1 L	Yes 2		28f. Location (S	Street and	Number or Rur	ral Route Number,	
Ξ Ž	al or A s after al Dire ed in b		. 4 ☐ Homicide determined	building, etc	. (Specify)				City or Tow	rn, State)	.,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 Medical Exam	iner: On the basis of ex	amination and/or	leath occured at the time investigation, in my opini	ion, death o	occurred at	the time, date a	ind place,	and due to the c	cause(s) and manner stated.	
	ithin 2 or the or the ormple	ž	29b. Signature and title of certifier		oest of my knowle	edge, death occurred at the 29c. Licens			e, and due to the	_	e signed (Month		
g	F > F 0		Willer	oceana		72	92	46		May	23, 20	10	
	•		30. Name and address of person who									. 0115	
7	FIVA	to.	Natjarlal Rajr 31. Date filed (Month, Day, Year)			shington A		Wes	tminst	er, N	1arylanc	1_2115/	
	Registr		MAY 24	20.0 > C8	assess 1	A. Jakes							

10-04050 Mary J. Wahl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

0	Ô	-	0	7	0	1
2	U	1	U	- [9	1

,		cate of Death	Reg. No.				
Physician/ Medical Examine	Decedent's Name (First, Middle,Last)	Mo	onth Day Year 1000 hrs				
Medical Examine	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death				
	Western Md Health System 5. Social Security Number 6. Sex 7. Age (In yrs. last b	irthday) If Under 1 Year If Under 24Hrs. 8. [Allegany Date of Birth(MM/DD/YYYY) 9. Birthplace (State or				
Funeral Director	219-46-0578 _{1 M 2XF} 65		1/11/1944 Foreign Marry land				
any	Usual Residence of Decedent 10a, State 10b. County 10c. City, Tow		10d. Inside City Limits				
Aaryland 18a-f show any 1at once. ector	MD Allegany Bar		1 X Yes 2 No 10g. Citizen of What Country?				
h the Maryland 13a or 28a-f sh totified at once	19301 South Railroad St.	10f. Zip Code 21 5 2 1	United States				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican 1 Yes 2 No specify:					
ours after attural" amine	4 Divolced in Fourth States of Page 1	a. Decedent's Usual Occupation (Give kind of work d					
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12	during most of working life. DO NOT use retired) Dietician	Hospital				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica FO BE Comple	17. Father's Name (First, Middle, Last)		, Middle, Maiden Surname)				
1121 Id be fill Aental I narked event,	Edward J. Ross 19a. Informant's Name/Relationship (Type, Print) 1	Gladys I 9b. Mailing Address (Street and Number or Rural F	Puffinbarger				
MD 21 d 2 should ulth and Me m 27 is ma n unatic ev	Irvin J. Wahl/ husband	19301 South Railroad St	Barton Maryland 21521				
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If iten 27 is marked other tt injury or other traumatic event, the Med	A GROUNT O GOVERNMENT OF BROWN STATE OF CHARLES	of Disposition (Name of cemetery, atory or other place) at Mem. Park 06/01/	20c. Location - City or Town, State 2010 Cumberland Maryland				
Baltii permit. Departm Importa	21. Signature of Funeral Service Licensee		Funeral Home				
Physician	23a, Part I. Enter the disease, or complications that caused the death. Do	not enter the mode of dying, such as cardiac or resp	rnport, Maryland 21562 ratory arrest, shock, or heart Approximate Interval				
/Medical Examiner	failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive Atherosclerot	tic Cardiovascular Disease	Between Onset and Death				
	or condition resulting in death) Due to (or as a consequence of): b.						
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clisacuse Listing Listing Cause)						
ted Insit	events resulting in death) Last Due to (or as a consequence of):						
execuian and ial - tre	d MENDED						
760, ficate be g physic the bur	IF FEMALE: 23c. If yes, outcome of pregnance 1 Live birth		23d. Date of delivery Month Day Year				
b. Box 687 the death certific by the attending I ched for use as the	past 12 months? 4 Pregnant at time of death 1 Yes 2 No 9 Unknown	2 Fetal death 3 Ectopic pregnancy 5 Other (Specify)					
P.O. Bc that the dea ned by the a detached fo	Part II. Other significant conditions contributing to death but not result	ing in the underlying cause given in Part I.	3e. Did tobacco use contribute to the cause of death?				
P.C. ires that signed be deta	End Stage Renal Disease; Diabetes Mellitus; Hypero	cholesterolemia	1 Yes 2 No 3 Probably 4 Unknown				
Vital Records, P.(ysician: The law requires tha his certificate has been signed director, page 2 should be det o Be Completed by			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?				
tal Rec cian: The la certificate h ector, page Be Com		1	Yes 2 No 1 Yes 2 No				
Vital ysician ysician directo	25. Was case referred to medical examiner? 1	26.Place of Death (Check only of Outpatient 3 DOA Other Nursing Hon					
Division of Vital Records, P.O. ral or Attending Physician: The law requires that th rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b		Describe how injury occurred				
isior Attender death rector: by the	2 Accident Investigation 28e Place of Injury - At home	1 Yes 2 No farm, street, factory, office building, etc. 28f. L	ocation (Street and Number or Rural Route Number, City				
Div pital or ours afte cral Dir filled in	The state of Death State of Death State of Specify) 2. Waltural 5 Pending Investigation 2. Accident Investigation 2. Accident Investigation 2. Accident Investigation 2. Accident Investigation 2. Specify) 2. Natural 5 Pending Investigation 2. Accident Investigation 3. Suicide 6. Could not be determined Investigation 2. Accident						
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as the Medical Certification: To Be Completed by Physician/	29a. Certifier 1 Certifying Physician: To the best of my knowledge, done) 2 Medical Examiner: On the basis of examination and/or and manner stated.						
Z Z	29b. Standure and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) May 28, 2010				
	30. Name and address of person who completed cause of death (Item 23a		maj 20, 2010				
3	Laron Locke MD. Assistant Medical Examiner 1	11 Penn Street, Baltimore, MD 21201					
State Registra		parl					

DHMH 17 Rev 1/2001 OCME 2006

OCME

ÖRIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2010 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hospital Prunce George Regional 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Funeral Year Days Min 1 X M 2 □ F Hours 219-48-9506 62 Director April 22, 1948 Cheverly, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 X Yes 2 ☐ No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 8107 20th Avenue 20783 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give Year or Dates: þ Specify: White 3 ☐ Widowed 4 🖾 Divorced "natural" Be Completed event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n 27 Is marked other than ", traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Automotive Mechanic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Randolph Worley Marian Rector ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian C. Marino / Mother 8107 20th Avenue, Hyattsville, MD 20783 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tronce. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 🖾 Cremation 3 Removal from State Metropolitan Crematory 5/29/2010 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (as a consequence of): onic Obstruction Pulmonary Discose Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
P Hours after death.
Puneral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) certificate has been signed by the rector, page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 **4**No 1 □Yes 2 II No 1 □ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 29b. Signature and title 29d. Date signed (Month, Day, Year) 055861

State Registrar 30. Name and address

Laurel Reg Hospital 7300 Vanbusen Rd Laurel MP 20707

of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar

Amended #8, nls, per FD 05/26/10, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	State Registrar			Cer	tificate of L	Death			Reg. No.	2010	17911	
Dhyro	iaiau	,	1. Decedent's Name (First, Middle	, Last)	_						Month Day Year		3. Time of Death	
Phys Me	edica		Thomas	James			Walber	t		3	22	/0°	1525 M	
Exa	mine	er	4a. Facility Name (if not institution,	,			4b. City, Town, or				4c. C	ounty of Deat		
ممد .			Western MD Regi						erland			Allegany		
Fune					e (In yrs. las 90		If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)19:	20 9. Birt	hplace (State or Foreign untry)	
Direct	tor	-	214-26-7896 Usual Residence of Decedent	- X 1	90	Yrs.				12/30	1919	- Mai	ryland	
nd how at	6	ا ج	10a. State 10b. County		10c. City,	Town or Loc	cation						10d. Inside City Limits	
anylau a-f s fied		St	MD All	egany		Cı	umberland						1 X Yes 2 □ No	
or 28		Director	10e. Street and Number		1		10f. Zip Code		-		10a Citiza	en of What Co	untry?	
vith th	10	<u>ra</u>	519 Pearre Av	roniio				1502				USA	and y .	
ath v ems		Funeral	11. Marital Status	12. Was Decedent	Ever in U.S.	13. V	Vas Decedent of Hi		in? (Spec	cify Yes or No-		I. Race - Ame	rican Indian	
orit Tine		by	1 Never Married 2 Marr	Armed Forces? ied 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	No 194		f Yes, specify Cuba	n, Mexican,	Puerto F	Rican, etc.)	- 1	Black, White		
O3 rs aft rral",	T V		3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates.	1945	5 1	☐ Yes 2 🔀 No	Specify:			S	pecify:	White	
nd 21215-0036 filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at		Completed		t's Education st grade completed)		16a. Deced	lent's Usual Occupa	ation	of workin	19	16b. Kind	d of Business	Industry	
Pin 72		E	Elementary/Seconday (0-12)	College (1-4 or :	5+)	life. Do	O NOT use retired)		UI WUIKII.	ig .				
Majorith Majorith			12	<u> </u>		Spor	rts Write	er			News	paper	· ·	
ind e filec sd ot		To Be	17. Father's Name (First, Middle, L		Walb	010 t				(First, Middle,		,		
aryland 21 tould be filed with the Mental Hygier is marked other the matic event, the		۲,		Salem	walb			Hele				dridge		
2 st a tha train			19a. Informant's Name/Relationsh Timothy J. Wal	1 1 21 1		19b. Mailin 602	g Address (Street a Washingt	and Number on St	r <i>or Rural</i> reet	Route Numbe	r, City or To erlan	own, State, Zip d , MD	21502	
of Heal		- 1	20a. Method of Disposition				sition (Name of		D	ate	20c. Loca	ation - City or	Town, State	
imor Page 1 nent of ant: If it			1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)				natory or other plac m @ Rocky		05/2	27/201d	F1	intsto	ne. MD	
Baltimor permit. Page 1 Department of Important: If it any injury or o	انه		21. Sign ture of Funeral Service		1		. Name and Addres						1 Home, P.A.	
a le le c	ouce.		MAIL A	Mayor			404 Decat				-		21502	
			23a. Part 1. Enter the disease, or	complications that cause	d the death.								Approximate	
Physicia	an/	9 9	shock, or heart failure. List o Immediate Cause (Final		,			acci	10	+)	Interval Between Onset and Death	
Medic	cal		disease or condition resulting in death)	a. Cenel Due to (or as			W C	166	C	71			3 days	
Examin	-												•	
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	ence of):								
uted id ansit		am	Cause (Disease or linjury that initiated events	C										
exec an ar rial-tı			resulting in death) Last	Due to (or as	a conseque	ence of):								
760 icate be executed physician and sthe burial-transit	.	/Medical	•	d										
68760 ertificate b ding physi se as the b	:	Ě	IF FEMALE:	1										
X 6 th cer tendi			23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live Birth	2 ☐ Fetal	death 3 ∟	Ectopic pregnanc	у			23	d. Date of del		
BO deat deat he at	·	Physician	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown	t time of de	eath 5	Other (specify)					Month	Day Year	
at the	i		Part II. Other significant conditio	ns contributing to death h	uit not resul	Iting in the II	nderlying cause giv	en in Part I		OOn Did to			the cause of death?	
es the signer be d		ا ھ				9	naony mg caaco giv	orrar area					robably 4 Unknown	
rds equir	-	etec												
law r has b e 2 st		Completed								24a. Was autor	osy	prior to o	topsy findings available completion of cause of	
The cate	2 6										rmed? 2 No	death?	2 🗆 No	
ital Ician Sertifi ector	1	m	25. Was case referred to medical examiner?	Hospital:	_		T.	ace of Death	n (Check	only one)	-			
Phys this		으	1 Yes 2 No 27. Manner of Death	1 Inpati 28a. Date of inju		R/Outpatien 28b. Time of	t 3 DOA Othe	4 ∟ Nur		ne 5 🗆 Resid			ify)	
DO ding h. After funer		Certificate:	1 Natural 5 ☐ Pending	(Month, Da	y, Year)	injury	28c. Injury work' M 1 □	rat ? Yes 2□ I	- 1	8d. Describe h	ow injury o	ccurred		
SiO often deat ctor: y the		Ĭ ∰	2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could r	not be	Inv - At hom	ne farm stre	et, factory, office	Tes Z	_	19f Location /9	tmot and I	Number or Pu	ral Route Number,	
Division of Vital Records, P.O. Box lal or Attending Physician: The law requires that the death crafter death. al Director: After this certificate has been signed by the atter of in by the funeral director, page 2 should be detached for up		ē	4 Homicide determi	building, et		10, 10,111, 0110	iot, ladioly, ollido		ľ	City or Tow		varriber or nar	a rioute rumbei,	
Spita Spita Spita Spita Spita		<u>ca</u>	29a. Certifier 1 Certifying	Physician: To the best of	my knowle	dge, death o	ccured at the time,	date and p	lace, and	I due to the ca	use(s) and	manner as sta	ted.	
e Ho 24 h e Fui		Medical	(Check 2 L Medical B	caminer: On the basis of a Nurse Practioner: To the	xamination a	and/or invest	igation, in my opinio	n, death occ	curred at 1	the time, date a	nd place, a	nd due to the o	ause(s) and manner stated.	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit			29b. Signature and title of certifier	11.17		J-, •	29c. License		,			signed (Month	, Day, Year)	
5+	- 1) //	- my		_	10.31	76	6		MA	14 24	2010	
		ŀ	30. Name and address of person w	/ho completed cause of d	eath (Item 2	23a) (Type, P	rint)							
nas			Vik Poona:				ive, Cumb	<u>erlan</u>	nd, M	1D 215	02			
	State		31. Date filed (Month, Day, Year)	32 Registra	ar's Signatu									
Regi	stra	r	MAY 25 20	10 Senson	Ju.	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ S. Zdanov Alexander 2010 9:58 P May Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Memorial Hospital Frederick Frederick 5. Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min 1 **X** M 2 □ F Months Hours April 27,1952 Russia 218-39-1200 58 Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director X☐ Yes 2 ☐ No Maryland Frederick Frederick 10e, Street and Numbe 10f. Zip Code 10g, Citizen of What Country? 23a Funeral must 577 Binford Court 21703 United States items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Examiner Black, White, etc. o 1 Never Married 2 XMarried þ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White "natural" 3 Widowed 4 Divorced Completed عاد. عد Medical F 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) and Mental Hygiene. is marked other tha Scientist Government Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental I tant: If item 27 is marked o ည Sophia Kladovshikova Sergey Zdanov 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 577 Binford Court, Frederick, MD 21703 Elena Zdanova / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date 1 Burial 2 ACremation 3 Removal from State 5 injury (4 Donation 5 Other (Specify) 5/25/2010 Frederick, Maryland Crematory 21. Signature, f Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home Opossumtown Pike, Frederick, MD 21702 Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events and Due to (o resulting in death) Last burialattending physiciar Physician/Medical seeme Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Day Month Year signed by the a ld be detached f Yes 2 No 9 Unknown ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No 1 Tyes မ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No X Natural 5 Pending s after death. Acciden Suicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical 29a. Certifier 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

within 2 To the I

only one)

31. Date filed (Month Day,

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

564

32. Registrar's Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed,(Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:25 AM SALLIE MAE INGRAM ANDERSON unc Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Citizens Nursing Home tarford Havre de Grace 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Months Days Hours Min. Jan 19 Year 939 N8rth Carolina 71 215-40-4759 Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Tes 2 No HAVRE DE GRACE HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a or Examiner must be Funeral U.S.A. 21078 Summer Squall 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 Widowed 4 Divorced If Yes, Give Specify: BLACK "natural", Year or Dates Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natuury or other traumatic event, the Medical ury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highe grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) COUNSELOR INTERVENTIONIST Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Benjamin Ingram Sr</u> Carrie Mae Martin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WY 82072 1559 N. 23rd St., Cynthia Williford/daughter Larmaie, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Nourial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Berkley Cemetery 6-11-2010 Darlington, MD 21. Signature of Funeral Service 22. Name and Address of Facility William C. Brown Comm. F.H. Mar Philadelphia Blvd. Aberdeen, art 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final cuident Physician disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. ed by the attending physician and detached for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Dutasin Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown is certificate has been signed by director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy within 24 hours after death.

To the Funeral Director, After this certificate I 25. Was case referred to nedical 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DO/ ursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 6 10 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31 Date filed Nonth, Day, Year) 32. Registrar's Signature State 2010 9

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

			riease	State of Man				-	_	=		
			1 - For State Registrar	State of Man		artment of <i>rtificate of</i>			eg. No.	7947		
			Decedent's Name (First, Middle, Last	")		-	200	2. Date of Dea	th	3. Time of Death		
	Physic /Medi		Mara A.	nuld				Month	Day Year	830 PM		
	Exami		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Deat	h	4c. County of Death			
			RIVERVIEW NURS			ESSE		 	BALTIN			
	Funeral		5. Social Security Number 6. Se		n yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days			8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)			
	Director		Usual Residence of Decedent		<u> </u>			11/07	/1922 MARY	LAND		
	nyland how		10a. State 10b. County		Oc. City, Town or Lo	ocation			1	Od. Inside City Limits		
	Ba-fs	cto	MD HARFOR	D	BEL A					1 □ Yes 2 No		
	with the	by Funeral Director	10e. Street and Number	2012	10f. Zip Code				10g. Citizen of What Country?			
	leath ns 23	erai	502 WEATHERBY 1	ROAD 12. Was Decedent Eve	ar in U.S. 13.1	2101		pecify Yes or No-	USA 14. Race - Americ	an Indian.		
9	after or Itar	E.	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No			Hispanic Origin? (S ban, Mexican, Puerl	o Rican, etc.)	Black, White,	etc.		
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show he Mudical Exal in ectrost be recitified at	d by	3 Widowed 4 □ Divorced	If Yes, Give 1 ☐ Yes 2 ☐ No Specify: Year or Dates:					Specify: WH	ITE		
15-("natu	Completed	15. Decedent's Edu (Specify only highest grad	ucation le completed)	(Give	dent's Usual Occu kind of work done DO NOT use retin	during most of wor	rking	16b. Kind of Business/Inc	dustry		
12	withii iene. than	omp	Elementary/Secondary (0-12) 4	College (1-4or 5+)		AMSTRES			SEWING			
	2 should be filed and Mental Hygid is marked other aumatic avant, t	Be C	17. Father's Name (First, Middle, Last)	0	JEE SEE	CHAICHE		ne (First, Middle, I				
<u>lar</u>	Mental Mental arked c	ToE	WALTER FIRA	X			KATHI	ERINE	SOWA			
Maryland			19a. Informant's Name/Relationship (T)	ype, Print)	19b. Mailir	ng Address (Stree	et and Number or Ru	ıral Route Numbei	, City or Town, State, Zip	Code)		
	1 and Health am 27 ther tr		_CAROLYN_DiCOCCC 20a. Method of Disposition		502_ 20b. Place of Dispo	WEATHE	RBY RD	BELAIR Date	MD 21015 20c. Location - City or To	oun State		
nor	Pages nent of I int: If its		1 Donation 5 Other (Specify)		cemetery, crer	natory`or other pla			BALTIMORE			
Baltimore,			21. Signature of Funeral Sarcice Livens				0,.		SEDALE FUN			
ñ	permit. Departr Importe any inji								IMORE, MD			
ľ			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the	e death. Do not ent					Approximate Interval Between		
A	Physician		Immediate Cause (Final disease or condition	a. Octorio	celente	Ciarve	Vacani	a Dingue		Onset and Death		
	/Medical Examiner		resulting in death)	Due to (or as a c	onsequence of):		•					
		er	Sequentially list conditions, if any, leading to immediate case. Enter Unitarying Cause (Disease or injury	b Due to (or as a c	onsequence of):							
	outed id ansit	Examiner	Cause (Disease or injury that initiated events	6								
0,	ate be executed nysician and he burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):							
68760,	icate b physic s the bi	dicai		d								
9 X	The law requires that the death certifica tte has been signed by the attending phoage 2 should be detached for use as the	/Med	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of delive			
Вох	death atten	cian	23b. Was decedent pregnant in the past 12 mooths? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 [4 ☐ Pregnant at tim	Fetal death 3	Ectopic pregnant Other (specify)	су		Month Month	Day Year		
0	at the de by the tached	Physician/M	9 Unknown	9□ Unknown								
s, P	es that gned b	by P	Part II. Other significant conditions co	ntributing to death but r	ot resulting in the u	nderlying cause g	iven in Part I.	23e. Did tol	pacco use contribute to the			
ord	w requires been sign should be		dirention	-				1 🗆 Y	es 2 No 3 Prob	ably 4⊕tonknown		
Vital Records,	e law has b	Completed	Hypertunic					24a. Was a autops perform	y prior to cor	psy findings available mpletion of cause of		
a			2. Was case referred to medical	elas desian	el '			1 ☐ Yes	2 🖳 1 ☐ Yes	2 🗆 No		
Ž		To Be	avaminar?	Hospital:	2 ER/Outpatien	it 3□ DOA C		ath <i>(Check only on</i>	e) ence 6 ⊡Other (Specif	()		
J Of	9 9		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time of	28c. Inju			ow injury occurred	,		
Siol	or:	catic	1 ☑ ¶atural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1]Yes 2 □No					
Division	el or Attendin after death. I Diractor: Af d in by the fu	Certification:	4 Homicide determined	28e. Place of Injury building, etc. (At home, farm, str Specify) 	eet, factory, office		28f. Location (Si City or Town	reet and Number or Rura n, State)	l Route Number,		
	To the Hospitel or Attu- within 24 hours after de To the Funeral Direct completely filled in by the		29a. Certifier 1 Certifying Phy	sician: To the best of n	v knowledge, death	occurred at the t	time, date and place	and due to the c	ause(s) and manner as s	ated.		
	tha Ho nin 24 h the Fur	Medicai	(Check only 2 Medical Exami	ner: On the basis of ex and manner stated	amination and/or inv	vestigation, in my	opinion, death occu	rred at the time, d	ate and place, and due to	the cause(s)		
	To the To the Comp	Ž	29b. Signature and title of certifier			29c. Licen	se number	2	9d. Date signed (Month,	Day, Year)		
			Himane Il	حلسد،		1219	1667	(-6-7010)		
	(oV		30. Name and address of per of who co				en Zuice,	Sugar to A	2,01.1			
	Sta	te	31. Date filed (Morth, Day, Year)	73(c C tel	Signature)	50x 01	Kin God HE	Marker				
	Registr		JUN 0 9 201	10	6 1	-16-1						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month JUNE Physician/ JOSEPH L. AMEREIHN 2010 4:30P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore 344 Elinor Avenue Baltimore County 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Maryland 1 X M 2 🗆 F 213~32~1606 77 Director Jan. Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 10a. State at Director r 28a-f sh notified a 1 Yes 2 KNO Baltimore County Baltimore Maryland 10e. Street and Number 10g. Citizen of What Country? ral", or items 23a o Funeral USA 21236 344 Elinor Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black White etc. ģ 1 Never Married 2 Married XX Yes 2 No If Yes, Give Korean 1 Yes 2 No Specify Specify: White "natural", Completed XX Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than, College (1-4 or 5+) Elementary/Seconday (0-12) Manager-Sunpaper Sunpaper Distribution 12th drade N/A is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Mental I 1 and 2 should be fill of Health and Mental item 27 is marked Mary Margaret Flannigan Elmer Amereihn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 Holly Springs Court Baltimore, Md. 21236 Joseph C. Amereihn (Son) injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of I ō 1XX Burial 2 Cremation 3 Removal from State 6~12~2010 Gardens of Faith Cem. Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) fighture of Funeral Service Licensee ²² NarsanhdreFuheral_Home 7401 Belair Rd. Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final odence Physician, disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine Due to (or as a nsequence of) if any, leading to immediate cause. Enter Underlying renons the burial-transi Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence, attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant 9 ☐ Unknown Pregnant at time of death signed by the at d be detached for 1 ☐ Yes 2 L 9 ☐ Unknown Hospital or Attending Physician; The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No should has been 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 performed 2 🗆 No 1 Yes certificate 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending 1 Yes 2 No 24 hours after death.

Funeral Director; A Accident Investigation the 6 Could not be within 24 hours after des To the Funeral Director completed filled in by th 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 130027693 se of death (Item 23a) (Type, Print) 30. Name and address of person who completed ca 6530 Walther Ave Boltimone 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

0-03253		Please Tvi	oe or Print i	n Black Inc	delible	Ink. Ensu	re All (Copies Are	Leait	ole.		
lames Bowers		St	ate of Maryla	and / Depar	tment	of Health a					0	17949
		1- For State Registrar		Cert	ificate	of Death			Reg. I	Security State of		
Physici Medical Exam		Decedent's Name (First, Midd)	le,Last)					Monti	of Death	y Year		ime of Death 716 hrs
inedical Exam		JAMES BOWERS 4a. Facility Name (if not institution	on, give street and nu	ımber)		4b. City, Town, o	or Location		27, 201	4c. County of		17 10 1113
		Johns Hopkins Bayvie		•		Baltimore	. 200411011	or Bookin				
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Ye	ear If Und	ler 24Hrs. 8. Date	of Birth (N	IM/DD/YYYY)		ce (State or Foreign
Director		214-62-9147	1XM 2F	57	7 Y	rs. Months Da	ays Hour	s Min.	. 3,	1952	Country)	md
		Usual Residence of Decedent		31				AUG	,	1752		i.M.
' any		10a. State 10b. County	-	10c. City, T	own or Loc	ation		2				. Inside City Limits
Aaryland 28a-f show 1 at once.	ō	MD BALTI	MORE	DUND	ALK						1 4	X Yes 2 No
Maryl 28a-i d at o	rect	10e. Street and Number				10f. Zip Code			10g. (Citizen of Wha	at Country?	
h the 3a or	Ö	202 CENTER ST.				21222			US.	A		
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral Director	11. Marital Status 1 X Never Married 2 M		cedent Ever in U.S prces?		Vas Decedent of H Yes, specify Cuba				14. Race - White,		ndian, Black,
er dea	Fur		1 Yes	2 X No					,			1
rs afte ural" miner	þ	3 Widowed 4 Div 15. Decedent's Education (Spe	orced If Yes, Give Yes or Dates:			Yes 2 X N			146	Specify: b. Kind of Busi	WHITE	
215-0036 be filed within 72 hours afte ntal Hygiene. rked other than "natural", ent, the Medical Examine	Completed	Elementary/Secondary (0-12)	College (1			most of working lit				7. rung of Busi	111633/1110031	u y
21215-0036 out to filed within 7 Mental Hygiene. marked other than cevent, the Medica	npfe	12TH			PAT	NTER				CONSTI	RUCTIO	DIN
15-0(illed wi Hygier d other	Cor	17. Father's Name (First, Middle,	Last)				18.Mother	r's Name (First, M	ddle, Maid			
21 be fill rrked rent, 1	Be	JAMES BOWERS						TIE A. B				
D 21 hould nd Me is ma	ပ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mail	ng Address (Stre	eet and Nur	mber or Rural Rou	te Number	City or Town	, State, Zip (Code)
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f short reaumatic event, the Medical Examiner must be notified at once.		NAOMI CHAVIS/C	COUSIN	los: 5		WALNUT				21222		
ore, Nes 1 and of Healtl		20a. Method of Disposition 1 Bunial 2 X Cremation	3 Removal fr			osition (Name of o other place)	emetery,	Date	20	c. Location - 0	City or Town	n, State
Page Page ment tant; or otl	:	4 Donation 5 Other So	pecify:	10	ARD			05/07/2	010	HANOVE	R, MD	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr		21. Signature of uneral Service	dicensee	<i>[[]</i>		Name and Addres				•		
		23a. Part I. Enter the disease,	y Ma	ng		2007-09 1	EASTE	RN AVE.,	BALT	IMORE,		21231
Physician M i		failure. List only one sase	on each line.						ory arrest, s	snock, or near		proximate Interval
Examiner		Immediate Cause (Final Isease or condition resulting in death)		osclerot:		rdiovascu	ılar d	disease			-	Death
		Sequentially list conditions,	b.	consequence ory.								
	ğ	if any, leading to immediate		consequence of):								
	Examiner	(Disease or injury that initiated	c. Due to (or as a	consequence of):						-		
ecuted and transit	Ж	events resulting in death) Last	d.	consequence ory.								
	Sa	X UNPENDED	`	3.677	001	(110/10 #						
60, ate be	Med	IF FEMALE:		per ME goutcome of pregna	3904 (5/10/10 1	rr		1	23d. Date of de	elivery	
Box 68760, e death certificate be ex the attending physician led for use as the burial.	Physician/Medical	23b. Was decedent pregnant in th past 12 months?	LIVED			etal death 3	Ectopie	c pregnancy		Month	Day	Year
OX eath c	sic	1 Yes 2 No 9 Unk	nown g Unkno	ant at time of deat	h 5 (Other (Specify)						
O. Bo, that the deathed by the att	된	Part II. Other significant conditi		death but not resi	ulting in the	underlying cause	given in Pa	art I. 23e.	Did tobaco	co use contrib	ute to the ca	ause of death?
ires that the signed by a be detached	2					, ,			Yes 2	No 3	Probably	4 Vnknown
ords, w require s been si should b	Completed by					_		24a.	Was an	24b. W	ere autopsy	findings available
COT law r has b	횰							- _	autopsy performed		or to comple ath?	etion of cause of
tal Rec		AF 100	_						Yes 2	No 1	✓ Yes	2 No
ital sician s cert	Be	25. Was case referred to medical examiner?	Hospital:	npatient 2 🗸 E	P/Outpatio		IOthor:	(Check only one)	5 Boot	danas e	Other:	
Division of Vital Records, tal or Attending Physician: The law requir is after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	£	1 ✓ Yes 2 No 27. Manner of Death			8b. Time of		ury at Work	Nursing Home 28d, Des		idence 6 injury occurred		
on C nding th.	흲	1 X Natural 5 Pend	28a. Date (Month,	Day,Year)			Yes 2			.,,		
iSiG Atte	<u>ig</u>	2 Accident Inves	tigation 28e Place	e of Injury - At hom	e. farm. str				tion (Stree	t and Number	or Rural Ro	oute Number, City
Division pital or Attenc ours after death teral Director:	Certification:		not be (Specify)	, , , , , , , , , , , , , , , , , , , ,		,,,	3 ,		own, State)			,
E B B B		202 Certifier	ysician: To the bes	t of my knowledge	, death occ	urred at the time of	late and pla	ace, and due to the	e cause(s)	and manner a	s stated.	
To the Hos within 24 h To the Fun completely	Medical		niner:On the basis o	of examination and								se(s)
/ F.≥ E. 8	Be	29b. Signature and title of certifier		areu.		29c. Licen	se number		290	d. Date signed	(Month, Da	ay, Year)
		(1111	111	r /		O.C.	M.E.		A	pril 28, 201	0	
	ŀ	30. Name and address of person	who completed caus	e of death (Item 2	3a)							
		Zabiullah Ali, M.D. A	Assistant Medica	al Examiner	111 Pe	nn Street, Bal	timore, N	MD 21201				

State 31. Date filed (Month, Day, Year)
Registrar

OUME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Blue 2010 Hnnie /Medical Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Y **Funeral** 219-40-7312 1□ M 2 🔀 80 Months Days Hours Mir Director Usual Residence of Decedent filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits imore Director 1 Ses 2 No \mathbb{D} 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Venue 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: \$ Specify: Blac 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) omes 19ineer 17. Father's Name (First, Middle, Last) Be ပ imas eo/a 19a. Informant's Name/Relation ship (Type. P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 Gwynn Ave Baltimore, MD 21229 hanie 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 R 3 Removal from State Bastimore of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) ACUTE MYOCARDIAL INFARCTION hour /Medical Due to (or as a consequence of) Examiner ACUTE PULMONARY EMBOLUS hour Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine DEEP VEIN THROMBOS'IS burial-tran that initiated events resulting in death) Last that the death certificate be execu Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy for in the past 12 mon Month Day Year 5 ☐ Other (specify) signed by the a d be detached f 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? BOWEL RESECTION 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No has 24a. Was an page 2 autopsy certificate 1 □ Yes 2 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Manual of Death 28a. Date of Injury (Month, Day, Year) After t 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide e Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only one) within 2 and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30 Name at ress of person who completed cause of death (Item 23a) (Type, Print) 21229 BALTIMORE, MARYLAND SNYDER MD. 900 S. CATON AVENUE 31. Date filed (Month) State 32. egistrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 2 2010 3:00P June Bernard J. Bradley Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Timonium Balto. <u>Stella Maris</u> 8. Date of Birth (Month, Day, Year) Comber 16,1924 9. Birthplace (State or Foreign Country) 4 Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Hours 1 \(\text{X} \text{M} 2 \(\text{D} \text{F} \) **Director** 219-18-2540 85 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Examiner must be notified at Director 1 Yes 2X No Md. Balto. Kingsville 10e. Street and Number 10g. Citizen of What Country? ò Funeral 23a USA 7021 Mt. Vista Road 21087 items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Arroed Forces?

1 Yes 2 Black, White, etc ō þ 1 Never Married 2 Married 2 🗌 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: If Yes, Give "natural", res, GIVE Year or Dates.1943-1946 Specify. 3X Widowed 4 □ Divorced Completed event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) r than " College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) Telephone Company Linesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alexander J. Bradley Anna E. Weber any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7021 Mt. Vista Road Kingsville, Md.21087 Frank G. Nelson, Sr. Step-son 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Entombment Gardens of Faith 6-7-2010 Balto. Md. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) DEMENTIA Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as the attending IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death the detached 9 Unknown 9 Unknown BERNARD BRADLEY as been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 of autopsy 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \square Residence 6 $\overline{\mathbf{X}}$ Other (Specify) **HOSPICE** 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, 2300 DULANEY VALLEY RD. CRNP TIMONIUM, MD 21093 State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

10-04306 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Dorthea Booker-Ferguson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Physician/ June 6, 2010 0846 hrs **Medical Examiner** Dorthea Michelle Booker-Ferguson 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** St. Joseph Medical Center 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** Foreign Baltimore, Country Maryland Months Min. Days Hours Director 215-94-4349 2 X F 32 Yrs Aug. 23, 1977 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No Maryland Baltimore County Towson permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she fill prove to other reamastic event, the Medical 2. miner must be notified at once Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20 Lambourne Road 21204-2800 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Armed Forces? White, etc. 1 Never Married 2 X Married 2 X No Yes Black 3 Widowed 4 Divorced If Yes, Give Year Yes 2 X No specify: Specify: ۾ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Educational Aide Education N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Booker Inez(Smith) Meyers 19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Julius Eugene Ferguson 20 Lambourne Road Towson, Maryland 21204-2800 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Itimore, crematory or other place) 1 Surial 2 Cremation 3 Removal from State (Baltimore County) June 12**,2**010 Piney Grove Meth.Cem. Reisterstown, Maryland Donation 5 Other Specify Gair 32. Name and Address of Facility.
Peaceful Alternatives Funeral & Cremation Center, P.A. 21. Signature of Funeral Service Jeffrey L. 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and /Medical Death a Diabetic ketoacidosis Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Hospital or Attending Physician: The law requires that the death certificate be executed ian/Medical X UNPENDED 25a,27,per ME C905 7/9/10 TI the attending physician ed for use as the burial Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) Physic 1 Yes 2 No 9 V Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. δ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed' 1 Yes ✔ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other this 1 Yes 2 No After 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 1 X Natural Pending 1 Yes 2 No 24 hours after death. Director: 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be determined Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) June 7, 2010 O.C.M.E.

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Røgistrar's Signature

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month BECKER EDFFREY 2010 7 - 35 Medical Tune 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville 3 Vallingby Circle If Under 1 Year If Under 24 Hrs g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Funeral 1 🖾 M 2 🗆 F Months Hours Min (Month, Day, Yea Director Pennsylvania 191-40-8139 60 Jan Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 X No Marvland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 3 Vallingby Circle 20850 United States items 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No ö 1 Never Married 2 X Mamied þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates "natural", White 3 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Research Analyst Government other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Becker Richard June Fortney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vallingby Circle Rockville, Maryland 20850 Leslie Becker/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State inal Journey Crematory 6/8/2010 4 Donation 5 Other (Specify) Woodbine, Maryland ure of Funeral Service Lice Going Home Cremation Service P.O. Box 784 M00957 Beverly L. Heckrotte, P.A. Clarksville, M 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 8 months shock, or heart failure. List only one cause on each line Immediate Cause (Final -Physician/ Non-small Cell Lung Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and -transit Exami Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) -burialphysician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 ding p use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No o Month Day Pregnant at time of death signed by the a a \ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has page 2 death? 1 Yes 2 No Yes 2X No 25. Was case referred to medical 26. Place of Death (Check only one) director Be 1 Tes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? iniury 5 Pending 1 🔀 Natural 2 No 24 hours after death. Funeral Director: A Investigation Accident 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 3 only one 29d. Date signed (Month, Day, Year) 29b. Signature and June 7, 2010 D0061083 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

Paul M. Thambi,

31. Date filed (Month, Day, Year)

M.D.

6420 Rockledge Drive, Suite 4200 Bethesda, Maryland 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 1:30A M **Physician** Charlette Butler 6 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMOre n/a SAINT AgnES
Social Security Number 6. Sex HEALTheare | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | April 7,1957 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 🖵 🗗 217-66-5716 53 MD Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Wedforl Even, iver a ust by natified at MD N/A Baltimore 1 1 Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 114 Parkin St. 21201 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specif Black 1 ☐ Yes 2 € No Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4or 5+) N/A Elementary/Secondary (0-12) Homemaker 9th N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ralph Royster, Sr. Ethel Mickey ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print)
Latonyetta Perez/Daughter 2416 Hollins Ferry Rd. Balto., MD 21225 other 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Zion Cem 20c. Location - City or Town, State Date 20a. Method of Disposition Department of Important: If It any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6/12/10 Lansdown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beverly D $^{22.\,\text{Name and Address of Facility}}$ Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 contaile 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** UNKNOWN MYOCHADIAL MFARCTION disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-tra Due to (or as a consequence of): physician Physician/Medical law requires that the death certificate the 35 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregr 3 Ectopic pregnancy Month in the past 12 mon Day Por 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown s been signed by the should be detachε 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy page certificate 2 No 1 ☐ Yes of Vital 26. Place of Death (Check only one) director Be 25. Was case referre examiner's Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28c. Injury at Work? 27. Manner Death 28b. Time of 28d. Describe how injury occurred After or Attending Division 1 atural Injury 5 | Pending within 24 hours are:

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2010 June 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimere Avenue Caton 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>010</u> Physician/ Lessie Fee Banks 3 01p June Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Future Care N/H Seton Baltimore N/A5. Social Security Number 218-22-7443 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Country) Days Min. 1 M 2 ST 92 Director Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director MD N/A Baltimore 1 K Yes 2 □ No 10f. Zip Code 21215 10g. Citizen of What Country? 4817 Beauford Ave. USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 Mo Black, White, etc 1 Never Married 2 Mamied 2 filed within 72 hours after Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo Specify: should be filed within 72 hours aft and Mental Hygiene. Is marked other than "natural", Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private Homes Domestic Worker 8th N/A18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) be 1 Hattie Gladden James Edward Fee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, . 19a. Informant's Name/Relationship, (Type, Print) Rosetta Smith/Niece permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau 4817 Beauford Ave. Baltimore, MD 21215 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 Cremation 3 Removal from State MD Natl Mem Pk 6/12/10 Laurel, MD 4 Donation 5 Other (Specify) 22. Name and Address of FacilitBeverly Signature f Funeral Service Licensee Cromartie F/S D. 2700 Edmondson Ave. Balto., MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final tentic Aneurusm PROBABLE KUPTURED IHORACIC Physician/ disease or condition Medical resulting in death) Examiner THERACIC AORTIC Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the bunal-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Live Birth 2 ☐ Fetal dea ☐ Pregnant at time of death Ectopic pregnancy in the past 12 mopths?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 5 Other (specify) signed by the a d be detached f Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown icate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate has 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 1 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) nd title of certifier 29d. Date signed (Month, Day, Year) 29b. Signature D0043375 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

XALCN W. JUNIUTT 2835 SHITH A SUITE 203 BACTIMONE, MD 21209

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year)

32. Registra 's Signa

SMITH AVE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2010 ROBERT CLTSSO JUNE **Physician** 2, 12:30AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE GENESIS ELDERCARE DUNDALK 8. Date of Birth (Month, Day, Year) 5 - 3 - 1 9 5 7 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Months Min MARYLAND 1 X M 2 □ F 218-68-2127 53 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. Count 10a State Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Modical Evantor is ust be nottlined at BALTIMORE ROSEDALE 1 Yes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Pages 1 and 2 should be filed within 72 hours after death with to nent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or items 23a or: 21237 U.S.A. 1702 COMMONS COURT Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes W No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify: WHITE þ 3 Widowed Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry BALTIMORE COUNTY Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOLS CUSTODIAN 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CLISSO EDITH (LEPPO) HAROLD L. မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1702 COMMONS COURT BALTIMORE, MD EDITH M. CLISSO/MOTHER 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If It any Injury or o N☐ Burial 2 ☐ Cremation 3 Removal from State HOLLY HILL MEMORIAL CARDENS 6-4-10 MIDDLE RIVER, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityCVACH/ROSEDALE FUNERAL HOME Signature of Funeral Service Licensee 1211 CHESACO AVE ROSEDALE, MD Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cruse on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) ed by the a 1 □ Yes 2 □ No Ö 9 Unknown signed by d ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part ! Division of Vital Records, þ 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 2 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes To the Hospital or Attending Physician: 26. Place of Beath (Check only one) Be 25. Was case referred to medical examiner? Hospital: Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 100 1 Inpatient 2 ER/Outpatient 3 DOA ၉ this 28a. Date of Injury (Month, Day, Year) After thi 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. Director: A id in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature an MI 31. Date filed (Month, Day, Year State back Registrar DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T = For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 05 Month Year 12:15 AM **Physician** 06 2010 Orbie Della Croaker-Tyson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Good Samaritan Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Dec. 20, 1944NorthCarolina **Funeral** Months Days Hours Min. 1 ☐ M 2 🔀 F **Director** 241-80-1923 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show ? is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinar must be notified at 1 ☐ Yes X No Parkville Director Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 U.S.A. Emge Road Funeral 8710 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Specify: Black þ 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Emma Lee Alston Wiley Croaker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
200 FT. Meade Road, Laurel, Maryland 20707 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 shument of Health and tank: If item 27 is m Michael Croaker Jones permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State GainesMemorialGardens6-13-10 Mebane, N.C. 4 ☐ Donation 5 ☐ Other (Specify) Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph_j sician Supsis Severe /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Property of the state of the sertificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the burial-transit Examir Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Murdany 06/05/2010 MD RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mahdi Yazdany 5601 Loch Raven Boulevard, Baltimore Maryland 21239 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Carke

		Ame	end #17, per Plea	\$6,0406/91/Po State of M	nt in Black I aryland / Dep	ndelible In artment of	k. Ensure A Health and M	All Copies <i>I</i> lental Hyg	Are Leg jiene	jible.		
		-	For State Registrar			rtificate of		Reg. No. 0 10 1958				
	Physicia		1. Decedent's Name (First, Middle, Assunta Mari	· ·				2. Date of Deat June 7	2. Date of Death Junte 7, Day 2010 Year 3. Time of Death			
_	Medic Examin		4a. Facility Name (if not institution, 4300 Cardwe)	give street and number)	Apt.319	4b. City, Town, o	or Location of Death ingham		4c. County Bal	of Death timon	ce	
	Funeral Director		5. Social Security Number 218-16-1395	6. Sex 1 □ M 2 □ ★ 7. Ag	e (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Jan 1	0 ^{//ear} 1926	9. Birthpla Country Mary	ace (State or Foreign	
		'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation				10	d. Inside City Limits	
	Maryia 28a-f s otified	irect	MD Balt	imore	Not	tingham					1 ☐ Yes 2 🔀 No	
	with the	Funeral Director	10e. Street and Number 4300 Cardwell	Avenue Apt.	319	10f. Zip Code 2 1	1236		10g. Citizen of USA		ry?	
036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 🔀 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates.		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto o Specify:	ecify Yes or No- Rican, etc.)		ce - America ck, White, et	c.	
21215-0036	ithin /2 hours ene. r than "natur the Medical	Completed by		t's Education st grade completed) College (1-4 or	(Give	edent's Usual Occu e kind of work done DO NOT use retired borer	during most of work	sing	16b. Kind of E		_	
and 2	be filed w antal Hygi ked other c event, t	To Be	17. Father's Name (First, Middle, L Luis Masucci	,			18. Mother's Nam Gabrie	ne (First, Middle, M		ne)		
, Maryland	d 2 should alth and Me 27 is marl er traumati		19a. Informant's Name/Relationsh John Calka-son		19b. Mail	ling Address (Stree	t and Number or Rui enue-Parkv	al Route Number, 7ille, Ma	ryland	21234		
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once.		20a. Method of Disposition 1 ☐ Burial 2 🄀 Cremation 4 ☐ Donation 5 ☐ Other (S	3 ☐ Removal from State	20b. Place of Disp cemetery, cre Evans Fund Cremation	osition (Name of ematory or other plants ral Chapel Services B	and 6-8	Date	20c. Location Forest		vn, State l, Marylan	
Baltı	permit. Departn Imports any inju		21. Signature of Funeral Service L	icensee. M& Freds	2	22. Name and Addr				925 34		
	nysician Medical Examiner	8 7	23a. Part 1. Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on each lir	d the death. Do not en	ter the mode of dy	ing, such as cardiac	or respiratory arre	P London		Approximate Interval Between Onset and Death	
	cate be executed physician and sthe burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c	a consequence of): a consequence of):			7	Ò			
BOX 68/60	to the Hospital or Attending Physician: The law requires that the deam certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3 at time of death 5	☐ Ectopic pregna☐ Other (specify)				ate of delive	ry Day Year	
S, P.O.	ires tnat tn signed by Id be detac		Part II. Other significant condition	ons contributing to death	but not resulting in the	underlying cause	given in Part I.		ves 2 No		e cause of death? ably 4 Unknown	
Division of Vital Records,	ne law requ te has beer age 2 shou	Completed by						24a. Was a autop perfor	rmed?	. Were autop prior to cor death? 1 Yes	sy findings available npletion of cause of	
<u>.</u>	ertifica ctor, p	Be C	25. Was case referred to medical examiner?				Place of Death (Che	ck only one)				
<u> </u>	Physic this or	은	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpa 28a. Date of in	tient 2 ER/Outpati	ent 3 L DOA		lome 5 Resid				
o uoi	tending death. tor: After the fune	Certificate:	1 Natural 5 Pendir 2 Accident Investig 3 Suicide 6 Could	ng (Month, Di	ay, Year) injury	M 1	ork? ☐ Yes 2 ☐ No	28f. Location (S			Route Number	
Divis	ital or At urs after or ral Direct led in by	al Cert	4 - Homicide determ	building, e	jury - At home, farm, s tc. <i>(Specify)</i>			City or Tow	n, State)			
	he Hosp in 24 hou he Funei ipleted fil	Medical	(Check 2 Medical E only one) 3 Certifying	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	evernination and/or inve	estigation in my oni	nion, death occurred	at the time, date a ace, and due to the	nd place, and d e cause(s) and n	nanner as sta	ated.	
	vith To t		29b. Signature and title of certifier	0		29c. Licer	nse number		29d. Date sign	ed (Month, I	Day, Year)	
			30. Name and address of person	who completed cause of	death (Item 23a) (Type	Print)	Relai	Red	Balt	ON	(1)2/22	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Pojis	rar's Signature	ha sh 1	10 10					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jume^{ut}5, 2010^{ey} 12:19P MARJORIE KIRTLEY CONNOR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Stella Maris Baltimore Timonium Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 M 2 F Days 02/27/1915 ear) **Director Maryland** <u>217-05-4</u>390 Usual Residence of Decedent 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 XXVo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 624 Dunkirk Road 21212 USA 12. Was Decedent Ever in U.S.
Armed Forces?
1 Yes No
If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: WHite 3XX Widowed 4 □ Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Kirtley Beatrice Uniack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 601 Anneslie Road Baltimore, Maryland 21212 John Joseph Connor Jr Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem Gardens June 15,2010 20a. Method of Disposition 20c. Location - City or Town, State 1XX Burial 2 Cremation 3 Removal from State Timonium Maryland Donation 5 Q Other (Specify) nature of Funer 22. Name and Address of Facility Mitchell - Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph sician/ ASPIRATION PNEUMONIA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): attending physician and for use as the burial-transif Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box in the past 12 months?
1 ☐ Yes 2 ☒ No
9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? death? 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 **X** No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 28b. Time of Certificate: 28d. Describe how injury occurred the Hospital or Attending X Natural 5 Pending injury 2 No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

X Continued Business To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title 29c. License number 29d. Date sigged (Month, Day, Year) 30. Name and add ess of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar JACKIE JONES,

TONE 5.

CONNOR

MARIORIE

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Ye at Margie В. 840 Crites 06 04 2010 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ranklin Douare If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex g. Birthplace (State or Foreign Country) West Virginia 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🗗 F Director Yrs. 232-54-4953 82 May 11, 1928 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural" or items 23a or 28a-f shov traumatic event, It of Medical Examinar must be notified at Director MD Baltimore 1 Ves 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1110 Steiger Way 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married timore, Maryland 21215-0036 If Yes, Give Year or Dates: <u>Ş</u> Specify: White 1 ☐ Yes 2 🕱 No 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teaching Asst. Baltimore City Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Roberts Sr. ပ Lo1a Everett 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald R. Crites (Husband) 1110 Steiger Way, Baltimore, MD 21205 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If It any Injury or o 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 6/8/10 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1 Index the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Unsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760. physician Physician/Medical use as the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Day Year P.O. signed by the a 5 ☐ Other (specify) □Yes 2 No q | Unknown g 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown cate has b page 2 sl 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes this Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA After thi funeral 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury death. ours after death.

leral Director; A
filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 Frankl 19rmus Ynne-31. Date filed (Month, Day, Year 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 6:45 AM June 6, 2010 LOUIS JOSEPH CAMPAGNA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Regional Prince George's Laurel Hospital Laure 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min. 1 □XM 2 □ F Director 164-18-8160 91 March 22, 1919 Sicily Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medicial Examination must be mailted at Director 1 Yes 2 □ No Prince George's Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1108 Marton Street 20707 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify. 2 Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Store Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Campagna ၉ Anna Campagna 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louis J. Campagna, Jr. / Son Olympic Street, Silver Spring, MD 20906 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 6/12/2010 | Laurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, M01103 Laurel, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) Re **Physician** ardio Diratoin /Medical Due to (or as a consequence of): monary obstructive Dispace Examiner Chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d, Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> icate has been si 7, page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate he completely filled in by the funeral director, page Division of Vital 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

State

Medical

29a. Certifier

(Check only

Mohamed 31. Date filed (Month, Day,

Registrar

DHMH 17 Rev 1/2001

N69247

Hospital

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

Tourky

Year)

7300 Van Dusen Road

Laurel Regional 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

oolan raar ona		Registrar	ificate of Death	, ,	No. 2010 17962			
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Josiah Paul Chun		2. Date of Death Month June 4, 201	Day Year 1402 has			
)		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of		4c. County of Death			
		6240 Solomons Island Road 5. Social Security Number		's Landing	Anne Arundel			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las 217-31-6551 1 x M 2 F 22 Usual Residence of Decedent	Months Days Hours Yrs.	Min. 01/27/	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD			
v any		10a. State 10b. County 10c. City, T	own or Location		10d. Inside City Limits			
Aaryland 28a-f show any 1 at once.	ţ	MD Anne Arundel 10e. Street and Number	Tracy's Landing	140	1 Yes 2 X No			
r death with the Maryland or items 23s or 28s-f sho must be notified at once,	I Director	6240 Solomons Island Road	10f. Zip Code 20779		g. Citizen of What Country? U.S.A.			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland ealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1f Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F 1 Yes 2 No specify:		14. Race - American Indian, Black, White, etc. Asian Specify:			
hours "natur	ted b		16a. Decedent's Usual Occupation (Give kir during most of working life. DO NOT us		16b. Kind of Business/Industry			
036 ithin 72 ne. r than '	Completed	College (1-4 or 5+)	Student		Education			
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", c event, the Medical Examiner	Be	17. Father's Name (First, Middle, Last) Jue Soo Chun	St	Name (First, Middle, Ma u Kyong Yi	500 ST			
and 2 should and 21 seath and Me ten 27 is ma traumatic ev	٩	19a. Informant's Name/Relationship (Type, Print) Nara Han/Sister	19b. Mailing Address (Street and Number 6240 Solomons Isla	er or Rural Route Numb and Rd Tra	er, City or Town, State, Zip Code) 20779			
ore, MI	1	20a. Method of Disposition 20b. Pla	ace of Disposition (Name of cemetery, ematory or other place)		20c. Location - City or Town, State			
Baltimore, permit. Pages I an Department of He important: If ite		1 X Burial 2 Cremation 3 Removal from State SOU	thern Mem Gdns		Dunkirk, MD			
Baltimo permit. Page Department o Important: injury or ott		21. Si, fatul of Funeral Serve Licensee Lisa M. Mounts			Home Calvert, P.A.			
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. Defailure. List only one cause on each line.	8125 Southern Mo Do not enter the mode of dying, such as care		t, shock, or heart Approximate Interval			
/Medical Examiner		Immediate Cause (Final disease a. Hanging			Between Onset and Death			
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.						
	ije	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause						
ed Isit	Examiner	events resulting in death) Last Due to (or as a consequence of):						
760, icate be executed physician and the burial - transit	Medical	d. UNPENDED X AMENDED						
760, icate be physicate the purities for		4b per ME G90 IF FEMALE: 23b. Was decedent pregnant in the	incy		23d. Date of delivery			
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and impletely filled in by the funeral director, page 2 should be detached for use as the burial - transition in the contract of t	Physician/	past 12 months? 1 Vop. 2 No. 0 Halaneum 4 Pregnant at time of deat	2 Fetal death 3 Ectopic p h 5 Other (Specify)	regnancy	Month Day Year			
D. B. It the de by the ached f		9 Unknown	ulting in the underlying cause given in Part	I. 23e. Did tob	acco use contribute to the cause of death?			
ires tha	Completed by			1Yes	2 No 3 Probably 4 Unknown			
ords w requ as been	plete			24a. Was an autopsy	prior to completion of cause of			
Division of Vital Records, tal or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should b	اق ق			perform 1 Yes 2				
ion of Vital Rectending Physician: The Leath. or: After this certificate I the funeral director, page	o Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 E	26.Place of Death (C		esidence 6 🗸 Other; Scene			
n of \ing Ph;		27. Manner of Death 28a. Date of Injury 2	28b. Time of Injury 28c. Injury at Work?		w injury occurred			
ivision I or Attendi after death. Director: d in by the f	catio	2 Accident Investigation Jun 4, 2010 1	FOUND: 1 Yes 2 ✔ N	0				
Divis spital or At hours after d ineral Direct y filled in by	Certification:	3 Suicide 4 Homicide 6 Could not be determined (Specify) Single Famil	eet and Number or Rural Route Number, City te) Island Road, Harwood, MD					
he Hospi in 24 hou he Funei pletely fi	4 Homicide determined (Specify) Single Family 4 Determined (Specify) Single Family 4 Determined (Specify) Single Family 4 Determined (Specify) Single Family 5 Determined (Specify) Single Family 4 Determined (Specify) Single Family 5 Determined (Specify) Single Family 5 Determined (Specify) Single Family 6 Determined (Specify)							
ro To With	Med	and manner stated. 29b. Signature and title of certifier	29c. License number		29d. Date signed (Month, Day, Year)			
		Q M. 1/	O.C.M.E.		June 5, 2010			
	Ī	30. Name and address of person who completed cause of death (Item 23 Jack Titus MD. Deputy Chief Medical Examiner	3a) 111 Penn Street, Baltimore, M	D 21201				
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature						
Regist		JUN 0 9 2010 Janua	1. parled	·				
DHMH 17 Rev 1/20 OCME 2006	01	, ·	ORIĞİNAL		OCME			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year ewer **Physician** arri 30 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1023 Lakemont Avenue **Baltimore** Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral M** 2□ F Months Days Hours Min Yrs Director 214-64-6367 57 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinat must be notified at 1 XYes 2 □ No Director Marvland **Baltimore Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1023 Lakemont Avenue 21228 U.S.A Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐No Specify ò Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Koppers Steel Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dewey Carrington Sr. Sarah Carrington ဂ္ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lorraine DeCruise 6507 Windsor Mills Baltimore, Maryland 21207 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/04/10 Baltimore, Md. Woodlawn Cemetery & Chapel Sign Hire of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. la Approximate Interval Between Onset and Death Immediate Cause (Final Physician rou disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner en Sequentially list conditions Examine day issuing to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed etes burial-trar Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ icate has been sig ; page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate performe Division of Vital 1 □Yes 2 XNo Physician: 25. Was case referred to medical funeral director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 ☐ Accident 5 Pending death. n 24 hours after death.

e Funeral Director: A letely filled in by the fu investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only To the I within 2 29c. License number

State Registrar

29b. Signature and title of certifier

llejamm 31. Date filed (Month, Day, Year)

JUN 0 9 2010

amma

Name and address of person who completed cause of death (Item 23a) (Type, Print)

mathew

32. Registrar's Signature

DHMH 17 Rev 1/2001

29d. Date signed (Month, Day, Year)

5411 old Frederick Rd # 1 Baltimose MD 2/229

l-04236 annette F. Cl	o ele	Please Type or Print in Black Inc				gible.	
annette F. Ci	aik	State of Maryland / Depar	tment of Health ar ificate of Death	nd Mental Hy	giene	2010	17964
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	Thousand or Bodin		Re 2. Date of Deat	eg. No.	3. Time of Death
edical Exam		beametee i. craix			Month June 3, 20	Day Year 010	1646 hrs
1		4a. Facility Name (if not institution, give street and number)		or Location of Death		4c. County of Death	1
		10635 Old Court Road	Woodstock			Baltimore Cou	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday) If Under 1 Ye Months Da		7	th(MM/DD/YYYY) 9. Bir Foreig	gn
Director		1 M 2 X F	48 Yrs.		03/02	2/1962 0	untry) NJ
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Location				10d. Inside City Limits
* .	_	MD Baltimore Wood	dstock				1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code		10	Og. Citizen of What Cou	ntry?
with the Maryland ns 23a or 28a-f sho be notified at once.		10635 Old Court Road	2116	53		USA	
h with ms 23 be ng	Funeral	11. Marital Status 12. Was Decedent Ever in U.S 1 X Never Married 2 Married Armed Forces?		lispanic Origin? (Spean, Mexican, Puerto I		- 14. Race - Amer White, etc.	ican Indian, Black,
r deat or ite	핕	1 Yes 2 X No			Nican, etc.)		
2 hours afte "natural", Examiner	þ	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	1 Yes 2 N		ort done	Specify: Bla	
72 hou "nat	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life			TOD. KING OF BUSINESS/	ridustry
036 ithin 7 ne. r thar	Completed	2yrs	Nurse			Health	
5-0 lled w Hygie other		17. Father's Name (First, Middle, Last)		18.Mother's Name		faiden Surname)	*
21215-0036 Muld be filed within 72 hours after the Muld Hygienen marked other than "natural", or event, the Medical Examiner	o Be	Unavailable		Helen			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Martal Hygiene and Propertment of Health and Martal Hygiene and Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ř	19a. Informant's Name/Relationship (Type, Print) Uinaca Clark Brother	19b. Mailing Address (Stre 226 Lincols				
and 2 and 2 Health item 2 traur			ace of Disposition (Name of ce		Date	20c. Location - City or	
nor ages l nt of l other		Touridit 2 Morcination 3 1 Removal from State	ematory or other place)	06/	06/10	Glam D	and MD
altin nit. P partme portan	1 3	4 Donation 5 Other Specify. At. 21. Signature Funeral Service Licensee	lantic 22. Name and Addres	ss of Facility Cim	00/10 plicit	y Crem &	ernie MD
E Per E	4	Thomas Allen	Thomas Al	llen PA	7090 F	Ridge Rd H	HanoverMD
Physician		23a Part I. Enter the disease, or complications that caused the death. E failure. List only one cause on each line.	o not enter the mode of dying	, such as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease a. Methadone and		oxication			Death
		or condition resulting in death) Due to (or as a consequence of):					
	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					1
	Examiner	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):					
executed an and ul - transit	Ĕ	d.					
	dical	▼ UNPENDED AMENDED 27 28 2-	-f, per ME G90	5 7/1/10	ւնսե		
760 icate b	/Me	IF FEMALE: 23c. If yes, outcome of pregna				23d. Date of delivery	
c 68 certif ending use as	cian	past 12 months?	2 Fetal death 3 h 5 Other (Specify)	Ectopic pregnar	су	Month D	ay Year
Boy e death the att	Physician/Med	1 Yes 2 No 9 V Unknown 9 Unknown	o O(ner (opcony)				
bat the	by P	Part II. Other significant conditions contributing to death but not resi	ulting in the underlying cause	given in Part I.		bacco use contribute to	
S, P uires t n sign Id be c	edt					2 No 3 Prob	
ord aw req as bee 2 shou	plet				24a. Was a autops	sy prior to d	topsy findings available ompletion of cause of
Rec The la	Completed				perform 1 ✓ Yes 2		s 2 No
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by funeral director, page 2 should be detach	Be	25. Was case referred to medical examiner? Hospital: 1 Inpution 2 1 5		e of Death (Check or Other Nursing			
F Vi Physi rer this	٠ <u>۲</u>	1 Yes 2 No	R/Outpatient 3 DOA 8b. Time of Injury 28c. Inju			Residence 6 Other ow injury occurred	: Scene
OD C ath. r: Af he fun	tion	1 Natural 5 Pending F. J. 6 / 2 / 1 O		·	nk	ow injury becarred	
/iSi r Atte ter des irrecto n by tl	Certification:		ne, farm, street, factory, office	building, etc.	8f. Location (S	treet and Number or Ru ate) 10635 01	ral Route Number_City
Diving the pital of the pital o	erti	4 Homicide determined (Specify) resider	nce	t	or Jown, St.	ate) 10635 OI Ck MD	d Court Rd
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	Sal	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge					
To th withir To the	Medical	one) 2 Medical Examiner: On the basis of examination and and manner stated.			the time, date a		
	2	29b. Signature and title of certifier	29c. Licens O.C.			29d. Date signed (Mor	nth, Day.Year)
		July Brown 4 Mb		.ivi. L.		June 4, 2010	
		 Name ånd address of person who completed cause of death (Item 2) Melissa Brassell, MD Assistant Medical Examine 		Baltimore, MD 2	1201		
S	tate	31. Date filed (Month, Day, Year) 22. Registrar's Signature	1			· · · · · · · · · · · · · · · · · · ·	
Regis	-	JIIN 11 & ZUIU Seneura 2.	Jackel				

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 6:00PM 2010 Rose Anna Delaney /Medical June 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Washington Med.

5. Social Security Number | 6. Sex | 7. A Center Glen Burnie
If Under 1 Year | If Under 24 Hrs. | **Arundel** Anne Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 □ M 2 🕅 F Director 41 5/8/1969 Maryland 216 08 1390 Usual Residence of Decedent 10a. State 10h. County 10c City Town or Location show 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, The Medical Exemination and the molified at Director 1 ☐ Yes 2 X No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with Funeral 269 Jay Jay Court 21061 death v United States Definit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or liverany injury or other traumatic event any injury or other traumatic event and other event and other event and other event and other event and other event and other event and other event and other event even 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Assistant Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Hackendorf Sr. ည Rose Marie Hayton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Edward Delaney/Husband 269 Jay Jay Ct. Glen Burnie, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Bonation 5 ☐ Other (Specify) 6/14/2010 Metro Crematory Catonsville, MD upe of Funeral S 21. Signi 22. Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 0 421 Crain Hwy. SE; Glen Burnie, MD 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MYPERTHALMA Immediate Cause (Final Physician MALIGNANT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ACIDO 853 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine sician and burial-transit Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ☑ No 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 ☐ Pending investigation death. 2 Accident 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

npletely within 2 U

P.O. Box 68760

Records,

ivision of Vital

State Registrar 31. Date filed (Month, Day, Year)

15,00

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T GALDMONE
32. Registrar's Signature

ORIGINAL

29c. License number

29d. Date signed (Month, Day, Year)

WASHINGTON MEDICAL (ENDON.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5 2010 Edward 11:10 A M Francis Dougherty Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel 1007 Lilac Lane Glen Burnie 9. Birthplace (State or Foreign 7. Age (In yrs. 78 8. Date of Birth Funeral 1 **X** M 2 □ F Months Hours Min. Month Day Year) 3-18-1932 Country) 216-28-7463 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10a State 10c. City. Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1007 Lilac Lane 21061 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Communication Installation Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thelma Schlotthober Leo Charles Dougherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 Lilac Lane, Glen Burnie MD 21061 Gloria Dougherty/wife 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 6/10/2010 Glen Burnie MD Glen Haven Mem. Pk. 4 Donation 5 Other (Specify) 22. Name and Address of FacilityKirkley-Ruddick Funeral Home 421 Crain Hwy Se Glen Burnie MD 21061 M01364 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Da Medical Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician for use as the burial signed by

Ph_sician/ Examiner

Baltimore, Maryland 21215-0036

2 should be detached page within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page Medical Certificate: To

29b. Signature and title of certifier

31. Date filed (Month, Day,

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

has

Division of Vital Records, P.O. Box 68760

disease or condition	a therefore process	gens
resulting in death)	Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	b	
that initiated events resulting in death) Last	C. Due to (or as a consequence of): d	
IF FEMALE:		
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	23d. Date of delivery Month Day Year
Part II. Other significant conditions of		id tobacco use contribute to the cause of death?
	p	/as an utopsy findings available prior to completion of cause of death? es 2 ☑ No 1 ☐ Yes 2 ☐ No
25. Was case referred to medical	26. Place of Death (Check only one)	
examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ R	esidence 6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	(Month, Day, Year) injury work? M 1 ☐ Yes 2 ☐ No	pe how injury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office 28f. Locatio	n (Street and Number or Rural Route Number, Town, State)
(Check 2 Medical Exami	sician: To the best of my knowledge, death occured at the time, date and place, and due to the ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date.	ite and place, and due to the cause(s) and manner state

29d. Date signed (Month, Day, Year)

10

State Registrar

	Physicia /Medic	ysician Medical William M. Diehl Jr. Medical					Month 5	- 1	Year 10: 50 AM	
and the same	Examin		4a. Facility Name (If not institution,			4b. City, Town, or			4c. County o	
and the			GOOD SAMARI			BALTIN If Under 1 Year	ORE,	₩ D	451	
	Funeral Director		218-22-2434		yrs. last birthday) 32 Yrs.	Months Days	Hours Mir		9 / •1 ^{r)} 927	9. Birthplace (State or Foreign Country) MD
	and		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Loca	ation				10d. Inside City Limits
	Maryl: -f sho	호	MD Balti	nore		Essex				1 ☐ Yes 2 🔯 No
	n the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of Wi	
	23a c	ral	252 North Ma	arlyn Avenue			21221			USA
9	i within 72 hours after death with the Maryland Jene. r than "natural", or items 23a or 28a-f show If a M-sifeal Extrainer must be rediffed at	Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie	12. Was Decedent Ever in Armed Forces? 1 ∑Yes 2 □ No If Yes, Give		as Decedent of H Yes, specify Cuba □Yes 2 ™ o		Specify Yes or No rto Rican, etc.)	- 14. Race Black Specify:	- American Indian, , White, etc.
003	ural",	d by	3 Widowed 4 Divorced	Year or Dates:					16b. Kind of Bus	White
15-	in 72 l	plete	15. Decedent's (Specify only highest	grade completed)	I (Give k	ent's Usual Occup ind of work done o O NOT use retired	during most of w	orking	Tob. Killa of bus	siness/industry
212	d within glene.	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)	Vide	eo Tech			John	Hopkins
pu	be filed tall Hygid double dou	Be	17. Father's Name (First, Middle, La	•				ame (First, Middle,)
yla	d 2 should be filed th and Mental Hygi ? is marked other traumatic event, II	은	William M. D.					a Benne		7-0-4
Baltimore, Maryland 21215-0036	nd 2 suith ar 27 is r trau		19a. Informant's Name/Relationship Pauline Diehl					Rural Route Numbe yn Aven		o MD 21221
ore,	S to II	1 1	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3		b. Place of Disposi cemetery, crema	tion (Name of atory or other place	ce)	Date	20c. Location - C	City or Town, State
<u>ti</u>	permit. Page Department of Important: If any injury of Once.	١,	4 Donation 5 Other (Spe	cify)	PArkwood			4/10	Baltim	ore MD
Ball	Depar Mpor Mpor any in		21. Signature of Funeral Service Li	censee P	22.	Name and Addre				Balto. MD
			23a. Part 1. Enter the disease, or co	omplications that caused the g	eath. Do not enter					Approximate Interval Between
	Physician ¹	V 1	shock, or heart failure. List or Immediate Cause (Final	nly one cause on each line.						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. MRSA B Due to (or as a con		vi A				
	Examiner		Sequentially list conditions	b. UROSEPS	15					1-2 WEEKS
	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):					
	execut and al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a con	sequence of):					
760	icate be executed physician and the burial-transit			d						
68	rtifical ng phy as th	Medi	IF FEMALE:							
O. Box 68760,	he death certificate be executed the attending physician and ched for use as the burial-transit	ysician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3 🗆	Ectopic pregnand Other (specify) _			23d. Date Mon	e of delivery hth Day Year
٠. ص	The law requires that the ate has been signed by the bage 2 should be detache	y Phys	Part II. Other significant condition	s contributing to death but not	resulting in the und	derlying cause giv	en in Part I.	23e. Did t	obacco use contri	bute to the cause of death?
of Vital Records	w requires s been sign should be	ed by	METASTATIC	MOH SMALL	CELL 1	LUNG C	ARCINOM	\A 1□'	Yes 2 □ No	3 Probably 4 Unknown
eco	e law re has bee je 2 sho	Completed						24a. Was	an 24b. W	Vere autopsy findings available rior to completion of cause of
<u> </u>		Com						perfo 1 □ Yes	rmed? 🦯 d	eath? □Yes 2 No
Vita	Physician: The I	B	25. Was case referred to medical examiner?	Hospital:		3□ DOA Oth	er.	eath (Check only o		
of	Phy: this	1:10	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatient 28b. Time of	3 DOA 28c. Injui	4 LI Nursing	Home 5 ☐ Resi 28d. Describe	dence 6 □Othe how injury occurre	
ion	nding lath. r: After e funer	atior	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day, Yea tion	r) Injury		k? Yes 2 □No			
Division	I or Attending after death. Director: After In by the funer	Certification: To	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin		At home, farm, street dec <i>ify)</i>	et, factory, office		28f. Location (City or To	Street and Numbe wn, State)	er or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		Physician: To the best of my kaminer: On the basis of exar and manner stated.						
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	and manner states.		29c. Licens	se number		29d. Date signed	(Month, Day, Year)
			► (FD	TUAKLI - WOSER	NU. mp	R	E5000		5 31	10
	(4)		30. Name and address of person w	ho completed cause of death	(Item 23a) (Type, P				·	
				WOSORMU, 5	GOI Loc	H RAVE	H BLYD.	BALTIM	ORE, m'	D 21239
	Sta Registr		31. Date filed (Month, Day, Year)	10 A. Registrar's S	ignature J. Law	del.				
DH	MH 17 Rev 1/2	-8	JUNUSZI	110	, ,,					,

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# IperpHYS, G (04, 6/22/2010, WS

Amend Item 4c State of Mary 100/100 for 100 f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗌 🗍 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1320 M Leon Dower Medical 2010 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sina Hospital City altimoro Balti 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 □ F Country) Alabama Days Hours (Month, Day, Year) Jul 5, 1931 **Director** Yrs. 422-34-9213 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a, State death with the Maryland 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits 1 🕇 Yes 2 🗆 No **Baltimore Baltimore** Maryland 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? 4508 Springdale Avenue 21207 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Matilda Dower King Dower 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trac Karen D. Crockett 507 Pintail Court Edgewood, Maryland 21040 timore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State COL 1 XBurial 2 Cremation 3 Removal from State 06/07/10 Windsor Mill, Md. 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park of Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A Eutaw Place Baltimore, Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ M40 (20) disease or condition Medical resulting in death) **Examiner** 48000 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Dav 1 Yes 2 9 Unknown 2 No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitu Diabeter 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Myber lension 24a Was an has autopsy performed? certificate 1 Yes 2 No Yes 2 WNo 25. Was case referred to medical B 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA eral Director: After this filled in by the funeral di 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury 1 ☐ Yes 2 ☐ No. Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) SUMIT KAPOOR MBBS RFS-000 31,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinau TIME

State

Registrar

31. Date filed (Month, Day, Year)

<u>IUN 0 9 20</u>

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ -Month Year P) UN 010 Medical Facility Name (if not institution, give street and number) 4b. City Examiner Town, or Location of Death 4c. County of Death MECLICAL L+ MORE Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) 1 X M 2 □ F Min Yrs. MARY LAND Director 217-50-7026 60 Usual Residence of Decedent show or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD. N/A BALTIMORE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? n of Health and Mental Hygiene, it if item 27 is marked other than "natural", or items 23a or or other traumatic event, the Medical Examiner must be a Funeral 2500 W. BELVEDERE AVE. 21215 USA permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items any injury or other traumatic persons. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 □ No Black, White, etc. 1 Never Married 2 XMarried þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 XNo Specify: BLACK Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) -12-DRIVER TRUCKING -0-Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 LAWRENCE ELLIS SR. THELMA LEWIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAULA ELLIS (WIFE) 2500 W. BELVEDERE AVE. BALTIMORE, MARYLAND 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place. X Burial 2 Crem ion 3
Removal from State GARRISON FOREST VETERANS 6-15-2010 OWINGS MILLS, MARYLAND 4 Donatio other (Specify) 5 🗆 HIBNER22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between e Cause (Final Onset and Death Physician eMORR diseas or condition resulting in death) 广 Medical Due to (or as a consequence **Examiner** Sequentially list conditions it any, reauting to immediate cause. Enter Underlying Cause (Disease or linjury Exam the Hospital or Attending Physician. The law requires that the death certificate be executed ng physician and as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Control of the contro in the past 12 months? Month Day Year Pregnant at time of death 2 No by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate Yes 2 No this certificaral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 **N**o 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? 1 Natural injury 2 🗀 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 5 29b. Signature e of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE ST BALTIMORE MD 21201

Registrar

V

State

Ate

31. Date filed (Month, Day, Year)

a

DHMH 17 Rev 7/2009

32. Registrar's Signature

10 NORY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 03PM JAMES 2Dio Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE 2527 HARIEM Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**X** M 2 □ F Months Hours Min. Director <u>243-16-6270</u> Usual Residence of Decedent ms 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director M Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2527 Harlem Avenue 21216 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, er than "natural", or ite the Medical Examiner Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: African-American 3 ₹ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Merchant Seaman of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Seafarers International Union 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willie Edward Gross Mary Magdalene Dance 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Emra Thomas/Daughter 2527 Harlem Avenue, Balto. MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-8-2010 Metro Crematory Baltimore, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. P rt 2 Enter the disease, or complications that cause: the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each tree. Approximate Interval Between Onset and Death Immediate Cause (Final ₽hysician/ OROW ARM disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner ASCU LAZ Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed 2 🗌 No 1 Yes completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident 1 🖵 Yes 2 🗌 No Investigation Suicide 6 Could not be 3 ☐ Suicide
4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 1046220 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch BA IT MORES MO 21218

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3 Day Physician/ Month 2010 Gee 9:20 a M James Edward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth XXM 2 D F Months Days Hours Min (Month, Day, Ye 220-01-1944 Yrs. Director VA Usual Residence of Decedent 28a-f show illouid be nec... and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Baltimore Director MD na 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U S 72 hours after death with 21218 922 Bonaparte Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Bace - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 1 Yes XXNo Specify: If Yes Give 3 X Widowed 4 Divorced Completed Year or Dates Black traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Bethlehem Steel Elementary/Seconday (0-12)
4th grade permit. Page 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If item 27 is marked other than College (1-4 or 5+) Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 FITZGERALD ELLA Ned Gee 2010 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 828 Kingston Ct Edgewood, MD 21040 Gladys Brown Gee-daughter Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State ō Mt Nebo Church CH 6-8-2010 Crewe, injury pnation 5 Other (Specify) March East F/H re of Funeral Service License 22. Name and Address of Facility Signat 1101 E. North Avenue Balto, MD 21202 art 1. Enter the disease, or complications that cause hock, or heart failure. List only one cause on each like he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ di lase or condition r ulting in death) GASTROINTESTINAL HEMORRHAGE Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate
cause. Enter Underlying
Cause (Disease or linjury Due to (or as a consequence of) for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) the detached P.O. by within 24 hours after death.

To the Funeral Director: After this certificate has been signed to completed filled in by the funeral director, page 2 should be detected. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires Records, 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy GEE performed 1 ☐ Yes 2 ☐ No Yes of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 2 🗶 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 5 \square Pending 1 🗶 Natural Division 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

CRNP

30. Name appl address of

se of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year CLARA H. GRAUER JUNE 2010 9:52A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death ST. JOSEPH MEDICAL CENTER BALTIMORE TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year 1914 Months Days Hours Min 212-01-8208 **Director** 95 Aug. Maryland Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore City Baltimore City 1XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3027 Oak Crest Avenue 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 14. Race - American Indian, Black. White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 XWidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. College (1-4 or 5+)
N/A Elementary/Seconday (0-12) 8 yrs Insurance Adjuster Insurance Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ George Hyman Louisa Newheiser t. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond Grauer (Brother-in-law) 3704 Meise Drive Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite tXX Burial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 6~7~10 Signature of Funeral Service Licenses ne and Address of Facility Lassann Funeral Home 7401 Belair Rd. Baltimore, Md. 21236 any 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. t and Death Immediate Cause (Final PULMONARY DISEAGE Physician/ OBSTRUCTUE HRON, C disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year ☐ Pregnam. ☐ Unknown been signed by the should be detached 1 ☐ Yes ∠
g ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ - INFARCT DEMENTA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an after death.

Director: After this certificate has yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending Investigation Accident pleted filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature a 29c. License number 29d. Date signed (Month, an D 00 ZO795 06 2010 30. Name and addr person who completed cause of death (Item 23a) (Type, Print) -MIN OSLER DRIVE STE 113 ND lowson SOLIDE 7600

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

Year)

32.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 29d per dr., g904, 06/09/2010dhb

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year Physician 7:02 PM MAL 2010 James Stafford Gardner Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAINT DES HEALThcare TIMOre AGN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Vear Months 57 214-76-0499 Feb. 1,1953 Maryland Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland not Mental Hygiene.

marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other trauπatic event, the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 938 Seagull Avenue 21225 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 ÑNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2X No Specify:Black Specify. þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9th grade **Unemployed** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked James Stafford Gardner Sr. Sadie Louis Sewell 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 2809 Federal Street Baltimore, MD 21213 Jozella Gilyard/Niece 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Pages 1 and Department of He 20a. Method of Disposition
1 ☐ Burial 2 Arcremation 3 ☐ Removal from State 20c. Location - City or Town, State Important: If its any injury or o once. 5/25/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, Maryland 21215 Approximate Interval Between Onset and Death 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gauseion each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of and Due to (or as a consequence of) Box 68760 death certificate be Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Ö 9 Unknown 9 Unknown The law requires that the signed by ئم 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has autopsy perform 1 □ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death

1 Natural

2 □ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation M 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one ner stated within 2 To the I 29b. Signal e signed (Month, Day, Year) tle of cer

State Registrar 30. Name and ad

31. Date filed (Month, Day,

IUN 09 201

W

SON S

X

4

900

pleted cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Jarne

mount

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month June Yea **Physician** 1:45 PM Thelma Lucille Galicki 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince Laurel Regional Hospita George's Laure 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🛛 🛣 Months Days Hours Pennsylvania 1921 212-18-4058 89 May 23, Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c City Town or Location 10a State 10h County 28a-f show traumatic event, the Medical Examinar must be notified at 1 □Yes 2 □No Director MD Anne Arundel Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Б 20724 U.S.A. or items 23a 303 Old Line Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or item any injury or other traumatic event, the Modical Eventual once. Black White, etc 1 ☐Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo Specify. Specify: White 2 3XWidowed 4 □ Divorced Completed Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12)
Grade 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mamie Dabrowska Ollie E. Avaritt ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) son 303 Old Line Avenue Laurel, Maryland Stanley Galicki, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 🖾 Aurial 2 🗆 Cremation 3 🗆 Removal from State Sacred Heart of Jesus 6/7/2010 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00770 UR -313 Talbott Avenue Laurel, Maryland 20707 Approximate Interval Between Onset and Death 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faill re. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Bacteremia Sequentially list conditions, if any, leading to immediate cause. Enter Uncerning Cause (Disease or injury that initiated events resulting in death) Last Examiner Tract attending physician and for use as the burial-transit Irinary Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Encephalopathi Hepatic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ▼No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t the Hospital or Attending 1 Natural 2 Accident 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D60936 June 3, 2010 7300 Van Dusen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Abdul Tak, MD Prince George HMG of Laurel. MD 32. Registrar's signature

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day,

9

3altimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records.

State Registrar

DHMH 17 Rev 1/2001

Baltimore

30. Name and address of person who completed chuse of death (Item 23a) (Type, Print)

320

31. Date filed (Month, Day, Year)

Bonson

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Michael Angelo ID DDA M Gentry 2010 unio Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Med Ctr Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) 72 yrs. . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 NC **Funeral** 1 🛛 M 2 🗆 F Months Days Hours 4-13-1938 215-34-1425 Director NC Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City. Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral 21060 101 Dorchester Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates white Specify: 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) School of Elementary/Seconday (0-12) College (1-4 or 5+) within permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the In Lab Technician 12 Pharmacy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ္ George Harrison Atkins Jr. Jennie Elizabeth Gangemi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Dorchester Rd., Glen Burnie MD 21060 Viola F. Gentry / wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Glen Haven Mem Prk 6/10/2010 Glen Burnie MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kirkley-Ruddick Funeral Home pature m01364 421 Crain Hwy SE Glen Burnie MD 21061 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Physician/Medical Examiner Duis to for as a nonsequence off cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and dbe detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown After this certificate has been significate has been significated after the second of Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 2 No မ 1 Tyes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, To the Funeral Director: After thi completed filled in by the funeral 28a. Cate of injury (Month, Day, Year) Certificate: 27, Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural N 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined To the Hospital 24 hours a Funeral I Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the 29b. Signature and title of 29c, License number 29d. Date signed (Month, Day, Year) 2010

State Registrar

0

30. Name and a

DHMH 17 Rev 7/2009

Barnet ms

Registrar's Signature

f person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician/ Medical Examiner 1. Decedent's Name (First, Middle,Last) TINA LOUISE HARANT 4a. Facility Name (if not institution, give street and number) 106 Fuller Avenue Funeral Director 213 94 9568 1 M 2 F 44 Vrs. Wonths Days Hours Mir Usual Residence of Decedent	Baltimore County							
4a. Facility Name (if not institution, give street and number) 106 Fuller Avenue 5. Social Security Number 213 94 9568 1 M 2 F 44 Yrs. 4b. City, Town, or Location of Death Baltimore Funeral Director 7. Age (In yrs. last birthday) 4b. City, Town, or Location of Death Baltimore Funeral Properties of the Company of t	h 4c. County of Death Baltimore County							
Tuneral Director 213 94 9568 1 Months Days Hours Mirector Baltimore Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr. Months Days Hours Mirector Mirector Mirector 1 Months Days Hours Mirector Mirector 1 Mire	Baltimore County							
Director 213 94 9568 1 M 2 F 44 Yrs. Months Days Hours Mir	P. Date of Birth (1414/DD00000) Q. Birth-lane (Clate							
Heust Residence of Decedent								
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits							
S. MD BALTIMODE DADKUTTIE	1 Yes 2 XNo							
MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 2909 SCHERER AVE 21234 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	10g. Citizen of What Country?							
9	USA specify Yes or No- 14. Race - American Indian, Black,							
11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No	o Rican, etc.) White, etc.							
3 Widowed 4 Divorced If Yes, Give Year or Dates:	Specify: WHITE							
15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret								
9 15. Decedent's Education (Specify only nignest grade completed) Specify only nignest grade completed) 15. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret during most of working life. DO NOT use ret 10	UNEMPLOYED							
L 경찰로컬 O 17. Father's Name (First, Middle, Last)	e (First, Middle, Maiden Surname)							
CHARLES J. WARD JR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or I	CA ANN ANTHONY Rural Route Number, City or Town, State, Zip Code)							
CAROL ANN WOOD/SISTER 37 THOMAS STONE CT	PORT DEPOSIT, MD 21904							
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State							
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature Fun myl S rivide Licensee 22. Name and Address of Facility CVA	BALTIMORE, MD							
21. Signature Fun not S rivie Licensee 22. Name and Address of Facility CVA	ACH/ROSEDALE FUNERAL HOME							
Physician 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of								
failure. List only one cause on each line. Immediate Cause (Final disease a. Combined Drug Intoxication (Meprobam	Between Onset and Death							
or condition resulting in death) Due to (or as a consequence of):								
Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):								
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	cause, Enter underrying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
dd.								
So as a series of the series o								
AMENDED 23a, 27 per me g906 8-18-10 vtt State Comparison Compar	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live high Section of Section							
23b. Was decedent pregnant in the past 12 months? Yes 2 No 9 V Unknown 9 Unknown 9 Unknown								
O 발 경우 보다 이 마이 마이 마이 마이 마이 마이 마이 마이 마이 마이 마이 마이 마	23e. Did tobacco use contribute to the cause of death?							
be detailed by the control of the co	1 Yes 2 V No 3 Probably 4 Unknown							
Records, The law require, page 2 should be Completed	24a. Was an 24b. Were autopsy findings available prior to completion of cause of							
Reco	performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No							
Description of Death (Check sexaminer? Hospital: 10 10 10 10 10 10 10 10 10 10 10 10 10								
Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?	ng Home 5 Residence 6 ✓ Other: Scene 28d. Describe how injury occurred							
27. Manner of Death 1	unknown							
Notice building, etc. Security 28f. Location (Street and Number or Rural Route Number, City								
determined (Specify) house 4 Homicide determined (Specify) house 29a, Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	106 Fuller Ave., Parkville, M							
Pending Investigation and/or investigation, in my opinion, death occurred at and manner stated. Pending Investigation and/or investigation, in my opinion, death occurred at and manner stated.								
■ 29b, Signature and title of certifier 129c, License number	29d. Date signed (Month, Day, Year)							
June 6, 2010								
II. I V IV/V: IV U VIIIVU I I I I I I I I I I I I I I								
30. Name and address of person who completed cause of death (Item 23a)								
30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 3 State 31. Date filed (Month, Day, Year) - 32. Relistrar's Signature	21201							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 06 6:35 AM Harold Haskins, Jr 2010 02 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) -6-1949 Months Days Hours Min 61 **Director** 217-54-1393 MD Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1 X Yes 2 ☐ No MD Baltimore na 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a 2840 Pelham Avenue 21213 S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) University of MD 12th grade <u>Custodian</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Harold Anthony Haskins Julia Joyce Dodd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Haskins-Wife 2840 Pelham Avenue Balto, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 Donation 5 Other (Specify) 6-9-2010 Crownsville, 21. Signature of Fun Service Lig 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, 21202 MD23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Deat Physician/ metantatic pancreas CANCER Medical resulting in death) **Examiner** Acute Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 X Yes 10 2 🗆 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 \square Yes 2 🗌 No Investigation 6 Could not be □ Accident filled in by the 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Dansa M.D.

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Leili Parsa MD, 201, E University pluny, Baltimore, MD

32. Registrar's Signature

At 243894666

06/02/2010

5

DHMH 17 Rev 1/2001

State Registrar 3.08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

821 N. Euteu St 31. Date filed (Month, Day, Year) K087625

MARCIA R. Soulsman,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary E. Hoffman June Ö8 2010 5:30 A. M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Peartree Assisted Living Pasadena Anne Arundel Social Security Number **Funeral** Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛣 Months Days Hours (Month, Day, Year) 04/07/1926 84 Director 219 20 6763 Mary land Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits Maryland Anne Arundel Baltimore 1 Yes 2 X No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 212 - 5th Avenue 21225 U.S.A. death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 5 Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after Yes 2 X No 1 Yes 2 X No Specify: "natural", If Yes, Give 3 XWidowed 4 ☐ Divorced Completed Specify: Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) 12th College (1-4 or 5+) Payrol1 M.T.A. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Dowling Mary Douglas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Hoffman / son 9453 Tiller Drive Ellicott City, Maryland 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🖪 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) any injury or Baltimore, Maryland 4 Donation 5 Other (Specify) 06/12/2010 Cedar Hill Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 Mannos 23a. P. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest phock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) ement 1-691 Medical a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 23d. Date of delivery in the past 12 mont Month Dav Year 1 ☐ Yes ∠ i Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No ျှ Other 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Softher (Sc Certificate: 27. Manner of Beath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Matural 5 Pending injury work? Accident Investigation 6 Could not be 2 🗆 No 24 hours after death Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2

To the 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29c. License number completed cause of death (Item 23a) (Type, Print) 11.09 31, Date filed (Month, Day

State

Registrar

32. Regi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

-								
2	0	1		2	971	0	0	
1		- 1	1 1		1	Sand	1.1	
6.00	Sec.	6	\sim	2	1	1	\cup	

		1- For State Certificate of Death Reg. No.	010 1750					
Physici Medical Exam		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day June 4, 2010	3. Time of Death 2114 hrs					
		10406 Fair Oaks Columbia Howar						
Funeral Director			99. Birthplace (State or Foreign Country Germany					
ne Maryland or 28a-f show any <u>fied at once,</u>	٦٢	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Columbia	10d. Inside City Limits 1 Yes 2 No					
n the Maryla 3a or 28a-f. otified at on	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of V 21045 US.	•					
fter death with ", or items 2	y Funeral	3 Widowed 4 Divorced If Yes Give Year	ce - American Indian, Black, nite, etc. Black					
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mernal Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f shoinjury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12th 15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Pharmacology Represent Pharmacology Represent	Business/Industry Macology					
MD 21215-0036 1 2 should be filed within 7 th and Mental Hygene. 127 is marked other than umartic event, the Medica	Be	Earl Melton, Jr. Shirley Jennings	ne)					
ore, MD 21 ss I and 2 should of Health and Me If item 27 is ma	ပ	Shirley Melton/Mother 2544 Druid Park Dr. Balto., M	ID 21215					
.드 스 일 등 등		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Cremation 5 Other Specify: Cockey	·					
		21. Signature of Fan ral Service Licensee 22. Name and Address of Facility Betts Funeral 1129 N. Caroline St. Balto.	, MD 21213					
Physician Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):						
	Jer	Sequentially list conditions, bb.						
ecuted and - transit	Examine	cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.						
O, e be ex ysician burial	Medical	UNPENDED AMENDED						
	Physician/M		of delivery Day Y ear					
P.O. B ss that the dagged by the	<u>اڇ</u>	1 Yes 2 No 3	tribute to the cause of death?					
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as:	Completed	24a. Was an autopsy performed?	Were autopsy findings available prior to completion of cause of death? Yes 2 No					
tal Recian: The certificate	B C	25. Was case referred to medical 26. Place of Death (Check only one)						
of Vi ing Physi After this	리	1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6	Other: Scene					
sion of Vital Rec trending Physician: The death. ttor: After this certificate t the funeral director, page	ation	27. Manner of Death 28a. Date of Injury FOUND: Day, Year) 1 Natural 5 Pending 2 Accident Investigation 28b. Time of Injury FOUND: 28b. Time of Injury FOUND: 1 Yes 2 No 28d. Describe how injury occur Subject inhaled carbon						
Division To the Hospital or Attendii within 24 hours after death. To the Funeral Director / completely filled in by the fi	Certification:	per or Rural Route Number, City						
To the Howithin 24 h To the Fun Completely	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manne one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.						
F 3 F 3	Me		ned (Month, Day, Year)					
8	-	30. Name and address of person who completed cause diceath (Item 23a)						
		Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201						
Sta Regist	:11.5							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 5:44 250ml Mara Medical 4b. City, Town, or Location of Death Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Raven Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday **Funeral** Min. 1 🔀 M 2 🗆 F Months Hours Director MARYLAND 8-19-1948 217**-**50-8842 Usual Residence of Decedent Show or 28a-f shov notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County hours after death with the Maryland Director MD. BALTIMORE CATONSVILLE 1 XYes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò "natural", or items 23a or edical Examiner must be Funeral 21228 407 MELVIA AVE ŪSA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 🗌 No 21215-0036 1 Yes 2 No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur lury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) CARRIER FOOD -12--0-Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ CLAUDIA JOHNS RICHARD HENSON SR. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CLAUDIA TUCKER (SISTER) 30 STONE PINE CT. PIKESVILLE, MARYLAND 21208 Baltimore, 20a. Method of Disposition 1 Burial 2 Cren 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 6-8-2010 permit. Page 1
Department of Important: If it any injury or o Cremation 4 Donation 5 🗌 Other (Specify) GARRISON FOREST VETERANS OWINGS MILLS, MARYLAND ice Micense TONATHAN D. HIBNER22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Duelto (or as a consequence of): Interval Between Onset and Death Physician/ Medical ue to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for es e consecuence off ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death the 9 Unknown P.O. s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Vunknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy yes 2 No 1 ☐ Yes 2 ☐ No certificate director, Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After t Certificate: Matural Natural 5 Pending 1 Yes 2 No death. 2 Accident
3 Suicide Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To the 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven 31. Date filed (Month, 'Day, Year) 32. Registrar's Signature State Registrar

Physician /Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and

Physician

/Medical

Director

Funeral

ð

Completed

Be

ပ

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner must be notified an once.

Hなるない レないい Baltimore, Maryland 21215-0036

ر 1

Physician/Medical Examiner ģ Completed Be

burial-tran the attending physician for use as certificate funeral director, After this 24 hours after deatle Funeral Director:

Division of Vital Records, P.O. Box 68760,

32. Registrar's Signature

25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical (Check only

and manner stated. 29b. Signature and title of certifier Medical Resident

JUN 09 2010

29c. License number RESODOO 29d. Date signed (Month, Day, Year) 6-3-2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR Maryann 31. Date filed (Month, Day, Year) FRANKLIN SQUARE DR BOLTO Md 21237 9000

State Registrar

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician UNE ones 06:45 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** N/A If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 218-70-9594 55 Yrs Director MD 1954 Dec. Usual Residence of Decedent death with the Maryland or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits N/A MD Baltimore Director 1 XYes 2 No 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö "natural", or items 23a o 744 Wharton Ct 21205 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2♥ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. If item 27 is marked other than "natural". or inanally injury or other trainments. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify Specify: Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 9th N/A N/AN/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown Jones Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 744 Wharton Ct. Baltimore, MD 21205 Sandra Jones/Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ardent Crematory 6/7/10 Hanover, MD 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** Hemoptysis disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Month Pregnant at time of death Year 5 Other (specify) 2 No the 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 🗌 No 2 XN0 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 \square Nursing Home 1 Inpatient ပု 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury s after death. 1 TYes 2 □ No 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide the Hospital 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) within 2 and manner stated 29b. Signature and title of certi-29c. License number 29d. Date signed (Month, Day, Year) 5-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Timothy

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Harris

MD

DHMH 17 Rev 1/200

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Lyelyn Jackson 2010 11:20 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Randallstown Seasons Hospice of Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth (Month, Day, Year) Feb 27, 1930 1 □ M 2 🔽 F Days Months Min. Hours Director Yrs 215-28-2678 Maryland Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🕇 Yes 2 🗆 No **Baltimore** N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21216 4218 Fairview Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Armed Forces o. Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give 27 is marked other than "natural", traumatic event, the Medical Exa Specify Black Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne
any injury or other traumatic event, the Medic
once. (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Administration Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Evelyn Cornish Benjamin Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4218 Fairview Avenue Baltimore, Maryland 21216 Angel Jackson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 06/08/10 Owings Mills, Md. Garrison Forest Veterans Cerhetery Signature of Funeral Service License 22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 213 25 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final disease or condition Onset and Death Cardiothrombotic event **Ehrysician** Medical resulting in death) Examiner cardiovascular there scientic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Physician/Medical Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the buria Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed cate has been signated by page 2 should by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No eral Director. After this certificate I filled in by the funeral director, pagr æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 1 No ၉ egitent hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other Si 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 29a. Certifie 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BSkyapanse M.D. D0057465

State

Registrar

2835 Smith Avenue, S-235, Baltimore, MD, 21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

N. S. Rajapakse, N.D.

JUN 09

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jun 2, 2010 Robin M. Johnson 5:20a Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1328 North Aisquith Street Baltimore N/A . Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 23, 1960 9. Birthplace (State or Foreign 1 M 2 V F Months Days Hours **Director** Maryland 216-84-1429 Usual Residence of Decedent items 23a or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho; any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits N/A **Baltimore** 1 ☐ Yes 2 ☐ No Md 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1328 North Aisquith Street 21202 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces?

1 Yes 2 X No 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No Specify: 3 Divorced Black Specify 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Company Housekeeping Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lonnie Johnson Mary Bazemore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rhonda N. Stokes 1005 North Central Avenue Baltimore, Md. 21202 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 06/08/10 Lansdowne, Maryland Mt. Zion Cemetery 21. Signature 1 Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. Eutaw Place Baltimore, Md 21 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ HRONIC OBST disease or condition resulting in death) Medical Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): use as the burial-transit attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): /Medical IF FEMALE: 23c. If wes, outcome of pregnancy signed by t Id be detach

Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

Be Completed by Medical Certificate: To

I yalcıdı	in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 Fetal death 3 Ect 4 Pregnant at time of death 5 Oth 9 Unknown	opic pregnancy er (specify)		-	23d. Date of d Month	delivery Day	Year
cied by r	Part II. Other significant conditions of	contributing to death but not resulting in the underly HYPERTENSION	ying cause given in Part I.	23e. Dic		use contribute		e of death?
2		N		per	s an topsy rformed? s 2 X N	prior to death?	completion	lings available in of cause of
3	25. Was case referred to medical examiner?		26. Place of Death (Check					
2	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Hor	ne 5 X Re	sidence 6	Other (Spe	ecify)	
	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b		28c. Injury at 2 work?	8d. Describe				
	4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)		City or To	own, State,	,		Number,
	only one) 3 Certifying Nurs	sician: To the best of my knowledge, death occure iner: On the basis of examination and/or investigatio se Practioner: To the best of my knowledge, death	 in my oninion death occurred at t 	the time date	and place	and due to the	couledel an	nd manner stated
	29b. Signature and Atle of certifier		29c. License number		29d. Da	te signed (Mon	th. Dav. Yea	ar)

DOOS8735

1000 E FAGER St, Bultimor MD 21202

29d. Date signed (Month, Day, Year)

State

Registrar

To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completed filled in by the fu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

31. Date filed (Month, Day, Year)

IUN 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Michelle Jean Kyzour June 5, 2010 Medical 1:45 AM 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death 9016 Chateaugay Court Baltimore Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Hours 219-58-2399 NOV. 8,1952 Director 57 Yrs Pennsylvania Usual Residence of Decedent 10a. State the Maryland 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified MD Baltimore Baltimore 1 🗌 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9016 Chateaugay Court 21234 USA . Page 1 and 2 should be filed within 72 hours after death iment of Health and Mental Hygiene. Fant; If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner m. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2X No þ 1 Never Married 2 Married Black, White, etc. Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) TCI Health Customer Service Team Leader Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ John Ira Winter Louise Mary Graff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Winter-brother 3134 Kings Court, Ellicott City, Maryland 21042 Baltimore, 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ott 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 🖵 Cremation 3 🗆 Removal from State Evars Fureral Chapel and June 11,2010 4 Donation 5 Other (Specify) Forest Hill, Maryland Cremation Services Belair 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chapel Road-Par ondrae L. ME Evans Funeral 8800 Harford 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ Squamous cell set and Death disease or condition cancinoma Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence on). the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events burial-tran resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d. Date of delivery in the past 12 months? signed by the at d be detached for Month Day 1 ☐ Yes 2 ↓ g ☐ Unknown Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

1 Yes 2 No autopsy performe After this certificate Yes 2 No director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🛣 No Hospital Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director. After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury Accident Investigation 1 🗌 Yes 2 🗌 No 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

N 0 9 2010 Lineson J. Jank

Name and address of person who completed cause of death (Item 23a) (Type, Print)

owson, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June 2010 4:30 AM Paul W. Krygar Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b City Town or Location of Death Crofton Care & Rehab Center Crofton Anne Arundel Birthplace (State or Foreign Country) . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. 1 5 M 2 1 F Hours 8-30-1928 **Director** 072-22-3878 81 NY Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 XNo MD Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? ō "natural", or items 23a o Funeral be filed within 72 hours after death with USA 8610 Fluttering Leaf Trail #407 21113 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than, Elementary/Seconday (0-12) College (1-4 or 5+) Education Rutgers University Admin. Page 1 and 2 should be filed wit ment of Health and Mental Hygie ant: If item 27 is marked other Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 Clive Iris Goring Krygar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heath a Important: If item 27 is any injury or other trat once. 8610 Fluttering Leaf Trl # 407 Odenton MD 21113 Rosalene Krygar Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 6-5-2010 4 Donation 5 Other (Specify) Arundel Crematory Odenton, Maryland Signature of Fun al Service Lica Donaldson Funeral & Crematory, P.A. 1411 Anapolis Road Odenton, Maryland M01176 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final taeta Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions If any, leading to immediate cause. Enter Underlying Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been accounted. Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trans Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ₩ No hours after death.

Ineral Director: After this certific
of filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Investigation Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year, 9x1 who completed cause of death (Item 23a) (Type, Print) Yerhoras Sw Glen Barne

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 06 OSEPH 08:55AM Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Anne Arundel Tate Hospice House Linthicum Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth Funeral 69 Months Days Hours Min. 07/04/1940 Marvland 220 36 6115 **Director** Usual Residence of Decedent 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No Anne Arundel Linthicum Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21090 U.S.A. 6302 Homewood Road filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 is marked other than " any injury or other traumatic event, the Mea any injury or other traumatic event, the Mea ginee. Elementary/Seconday (0-12) 12th College (1-4 or 5+) Plumbing & Heating Plumber Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John F. Kusiak Veronica C. Yastremski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linthicum, Maryland 21090 6302 Homewood Road Clement Kusiak / Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem._Park 06/07/2010 22. Name and Address of Facility Gonce Funeral Service, P.A. Signature of Funeral Service Licensee Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) Due to (or as a consulta ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? for Month Dav Yea Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Kores 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) TATE 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 1 Natural HOUSE 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

Registrar
DHMH 17 Rev 7/2009

ause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** P^{M} 5 2010 1:24 June Kelbie Mary J. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard 4991 Walking Stick Road, Ellicott City Apt. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 👿 F 65 15, 1944 Director 276-44-3487 Louisiana Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a fredical Examination outside 2 1 ☐ Yes 21 No Director Maryland Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21043 Funeral 4991 Walking Stick Road, Apt. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify. \$ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Steward ပ Thomas Johnston and Nis ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 19a. Informant's Name/Relationship (Type. Print) 4991 Walkington Stick Road, Apt. I Ellicott City,MD permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr. once. 27 Nelson Kelbie Husband 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Spring Grove 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6-12-2010 Cincinnati Cemetery 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Sixualur Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final OVARIAN WIN TOMATH **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature of title of certific State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	- Claro of Maryla	-	rtificate of			Reg. No	1799	Mary respective
Physician /Medical Examiner			Decedent's Name (First, Middle, La	•	,			2. Date of De Month	Day Voo	3. Time of Death	
			Grac 4a. Facility Name (If not institution, gi	4b City Town o	r Location of Deal	June	4c. County of De		M		
~	EXCIIII	iei	Augsburg	e estect and nambery		Baltin		V	Baltimo		
	Funeral Director		212-12-1013	Sex 7. Age (In yrs 1□ M 2 🛛 F 89	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		th 9. B ay, Year) 9. B 1920 Ma	irthplace (State or Fore Country) aryland	∌ <i>ig</i> n
	yland now		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limi	nits
	e Mar	Director	Md. Baltimo	re Ba	altimor	e				1 □ Yes 2 🗶 N	No
	with th		10e. Street and Number	D.J.		10f. Zip Code	207		10g. Citizen of What C		
	ms 23	Funeral	6811 Campfield	12. Was Decedent Ever in t	J.S. 13. V	212 Was Decedent of H		Specify Yes or No		JSA perican Indian	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Eversities and the reliable and once.	þ	1 X Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 □Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H fYes, specify Cuba I∐Yes 2∐XNo	Specify:	to Rican, etc.)			
15-("natu	letec	15. Decedent's E (Specify only highest gra	ducation ade completed)	16a. Deced	lent's Usual Occup kind of work done OO NOT use retired	pation during most of wo	rking	16b. Kind of Busines	s/Industry	
212	d within giene. r than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		etary	a)		Legal		
nd	2 should be filed and Mental Hygi is marked other aumatic event, I	BeC	17. Father's Name (First, Middle, Last			3 U.I. J	18. Mother's Nar	me (First, Middle,	Maiden Sumame)		
ryla	should band Men. marked marked	ပ္	Dickran Kachado				Armeno		emirjian		
Mai	nd 2 sh Ilth and 27 is n r traun		19a. Informant's Name/Relationship (Mr. George Kachad						er, City or Town, State,	Zip Code) e, Md. 212	28
ore,	ss 1 and 2 of Health item 27 i		20a. Method of Disposition	20b.		sition (Name of natory or other place		Date	20c. Location - City o		
ij	Pages tment of tant: If its jury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other <i>(Speci</i>	i nemovar irom State i		Mem. Par		10	Baltimore,	Md.	
Ball	permit. F Departm Importar any injur		21. Signature of Funeral Service Lice	isee ()	22	Name and Address 1050	Towson F York Rd.	uneral H Towson,	lome, Inc. Md. 21204		
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause in each line.	th. Do not ente	er the mode of dyir	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between	Ţ
Sea.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. ADREN		ANCE	R WIT	TH M	ETASTASE	Onset and Death	
	Examiner			Due to (or as a consec	quence of):						
-	pa ti	iner	Sequentially list conditions, if any, leading to minimediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consec	quence of).						<u> </u>
D.	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a consec	ruance of):						
68760,	e be e			4	quence on.						
	ertificate be executed ing physician and as the burial-transit	Medical	IF FEMALE:	. U.							
Вох			23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnanc	у		23d. Date of de		
o.	at the de by the a tached f	Physician/	1 □Yes 2 ☑No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5□	Other (specify)			Month	Day Year	
ς, σ.	iires that signed b d be deta	by Ph	Part II Other significant conditions of	ontributing to death but not res	sulting in the un	derlying cause give	en in Part I.	23e. Did to	bacco use contribute	to the cause of death?	
ord	w require been signated should b	ted b	DYSPHACTIO	9				1 🗆 Y	′es 2□No 3□F	Probably 4 hknow	wn
Records,	e law r has be	Completed						24a. Was a	sy prior to	utopsy findings available completion of cause of	ole of
			25 Mac cana referred to medical					perfor 1 □ Yes	med? death?		
>	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	1 FR/Outpatient	3 DOA Othe	ar.	th (Check only of	ne) lence 6 ☐ Other (Sp.	16.1	-
Division of	ng Ph After th Ineral	L:uo	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	y at		ow injury occurred	3CHY)	
<u>s</u>	ttendi death. stor: A	ertification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 🗆	Yes 2 □ No				
2	al or A s after I Direct	ertit	4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, tarm, stre	et, factory, office		28f. Location (S City or Tow	Street and Number or F n, State)	ural Route Number,	
	To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director. After th completely filled in by the funeral	ledical Co	29a. Certifier Check only one) Certifying Ph	ysician: To the best of my kniner: On the basis of examination and manner stated,	owledge, death ation and/or inv	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	e, and due to the dirred at the time, o	cause(s) and manner a date and place, and du	as stated. e to the cause(s)	_
	To the within To the Compl.	Me	29b. Signature and title of certifier	A.		29c. License	e number	1	29d. Date signed (Mon	th, Day, Year)	_
	_		Jasue		aun	w D	28195	-	6/2/10		
	5	<	30. Name and address of person who of TASNEDM LA	completed cause of death (Iter	m 23a) (Type, F	rint)	21.17	R RA	17 111	91240	
	∠ Stat	e	31. Date filed (Month, Day, Year)	32. Registra's Sign	1 37 S	2001 LG 1,	>4/16 2	03, 1217	CIO MI)	010	
	Registra	٠ ا	111N 0 9 2010 Z	known A. A.	Constant						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ RUCE LASTER 16:02 PM JUNE 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death NAExaminer BALTIMORE BON SECOURS HUSPITAL 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Min. (Month, Day, Year) 1 X M 2 - F Director 218-58-5036 58 Usual Residence of Decedent 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at within 72 hours after death with the Maryland Director XX Yes 2 \ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21223 USA 524 N. Gilmor Street and Mental Hygiene. Is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status

1 Never Married 2 Married 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?,
1 Yes 2 No Black, White, etc. African 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: American 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>8th Grade</u> <u>Sanitation worker</u> Baltimore City Be permit. Page 1 and 2 should be file.
Department of Health and Mental Humportant; if item 27 is martany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gailes Sis Laster Amos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5501 Purdue Avenue Baltimore Maryland 21239 Bridgett Laster-Niece 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
Metro Crematory 06-09-10 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licensee Gilmor Street Baltimore.MD N. 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pnysician/ STAGE AIDS disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami as the burial-transi Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death asn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Por in the past 12 months?
1 ☐ Yes 2 ☐ No Day ed by the a detached f 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by INFECTION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown NEUROSYPHILLIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No PANCREATITI 1 🗌 Yes 25. Was case referred to medical examiner?

1 Yes 2 No completed filled in by the funeral director, 26. Place of Death (Check only one) Other: 1 Npatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this s after death. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120 22 SOUTH GREENE ST

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2016ar Physician/ 6^{Month} Lawrence Leary 3 James 7:10 P Medical 4a. Facilify Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 7201 Ohio Ave. Hanover If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth (Month, Day, Apr. 30 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1 🛛 M 2 □ F 216-50-2748 Hours Min. 1947 Maryland 63 Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland tall Hyglene. ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No |Maryland |Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7201 Ohio Ave. 21076 United States 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1

Yes 2 □ No Black, White, etc 1 Never Married 2 X Married ğ Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 Divorced Completed Year or Dates. Viet Nan White 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) age 1 and 2 should be filed ent of Health and Mental H it; If item 27 is marked of y or other traumatic even Francis Leary Constance Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7201 Ohio Ave., Hanover, Maryland 21076 Sandra K. Leary / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State June Date 9, Page 1 2 X Cremation 3 - Removal from State permit. Page Department of Important; If any injury or once. Metro Crematory, Inc. 4 Donation 5 Other (Specify 2010 Catonsville, Maryland Sign 22 Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 42I Crain Hwy. S.E., Glen Burnie, MD 21061 ral Se Licente 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Caset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ Curs Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury as been signed by the attending physician and 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician. The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physicial completed filled in by the funeral director, name 2 should be attending physicial. Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 9 Unknown 9 Unknown Part II Other significant conditions contributing to d esulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1 🗌 Yes 2 ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5X Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending Natural M Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only or of certifier 29b. Signat Date signed (Month, Day, Year) who completed of

DHMH 17 Rev 7/2009

State Registr<u>ar</u> 31. Date filed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 4:34 2010)ai Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** timor 8. Date of Birth Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Days Month, Day, Hours Min. 1 M 2 D F **Director** Usual Residence of Decedent it of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No timure m1) 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? by Funeral USA 21215 . Was Decedent Ever in J.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 Married 2 No 1 Yes If Yes, Give 21215-0036 1 ☐ Yes 2 ☑ No Specify. 3 ☐ Widowed 4 ☑ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) မ 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Baltimore, Place of Disposition (Name of demetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greene Funeral Services 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Kead Randailstown MD 21132 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ost hemberha Physician/ -0P day disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** day resection Colon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of Mont Colovesicu physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Month Day Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dee within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 1 Yes 2 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by dependent 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? disease 24a. Was an performed Type U diabetes 1 Yes 2 No 25. Was vase referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ္ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 \square Pending 2 🗌 No 1 Yes Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) June -000 Ye 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE HOSPI TAL SINAI INGXIANG 31. Date filed (Month, Day, Year)

State

Registrar

JUN 0 9 20

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Virginia Elizabeth McCorkle 2010 12:45 P.^M June Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner Gilchrist Hospice Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Tune 21 1 □ M 2 🕱 F Months Days Hours 413-10-5126 90 1919 Tennéssee Director Tune Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland Director Parkville 1 Yes 2 X No Maryland Baltimore 10f. Zip Code 10e. Street and Numbe Citizen of What Country? United States Funeral 21234 8820 Walther Blvd. Apt. 2116 of America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes XX No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes XX No Specify: Page 1 and 2 should be filed within 72 hours aftiment of Health and Mental Hygiene. Fast; if tem 27 is marked other than "natural", any or other traumatic event, the Medical Examiny or other traumatic event, the Medical Specify: Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Residence Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Callie Upchurch (nee Stewart) Owen Upchurch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10719 Pot Spring Road Cockeysville, Maryland 21030 Marie Mullaney/daughter permit. Page 1 and 2 Department of Health Important; If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Fyans, Funeral Chapel – Bel Air 20c. Location - City or Town, State 20a. Method of Disposition June 5. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 2010 Forest Hill, Maryland 22. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A 21. Signature of Funeral Service Lice 2325 York Road Timmium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Stroke Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Nuknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed 2 No Yes 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. weducat zammer. Of the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier June 4, 2010 Ma R149194 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marion Grant 6701 N. Charles TOWSON

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

amend item 5 per fb 9904 6-23-10 yt State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Monther Day Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Baltimore Seasons Hospice Randallstown Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** Days Feb. 191 🗶 M 2 🗆 F Months Hours Min. North Carolina 218-62-1081 69 T941 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director MD 1 X Yes 2 No Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 6748 Brookmont Dr. 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces? 1 Never Married 2 Married ģ 3altimore, Maryland 21215-0036 hours after Specify: Black 1 ☐ Yes 2 ☐XNo If Yes Give Specify "natural", 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 1 2. College (1-4 or 5+) Assembly General Motors Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ပ Andrew Shaw McMillan Hattie Belle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health ar If item 27 is Yvonne T. McMillan (Wife) 6748 Brookmont Dr., Baltimore, MD 21207 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of F Important: If it any injury or o Baltimore Crematory 1 Burial 2 🛣 Cremation 3 🗆 Removal from State 6/10/10 Baltimore, Maryland 4 Donation 5 Other (Specify) @ Loudon Park Signature of Funeral Service Licensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: ase a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year ģ Month Day Pregnant at time of death 1 Yes 2 9 Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably → Unknown been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 Tes 2 🗆 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) funeral director, ဂ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After work? Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of ce lifier 29c. Lic 29d. Pate signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year, 32. Registrar's Signature State ar the 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death 3. Time of Death Physician/ 20 10 Morekas June 6:20 John a M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Towson Baltimore Gilchrist 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Funeral 1 XM 2 □ F Months Days Hours Min. (Month, Day 81 Féb. Director 212-28-6242 Usual Residence of Deceden 28a-f show 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a State death with the Maryland Examiner must be notified at Director Baltimore Timonium 1 Yes 2 X No Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5 Funeral items 23a 21093 USA 400 Plumbridge Court #203 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. ò 1 Never Married 2 X Married ģ Maryland 21215-0036 72 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates White "natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Salesman of Health and Mental Hygi item 27 is marked other other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk
Department of Health and Mental I
Important: If item 27 is marked o
any injury or other traumatic eve ဂ္ Katina Skalkeas Spiros Morekas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 Plumbridge Ct. #203 Timonium, Md. 21093 Mrs. Helen Morekas/ Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State cemetery, crematory or other place, 6-11-10 Woodlawn, Md. Greek Orthodox Cem. 4 Donation 5 Other (Specify) ^{22. Name an}Rûck^{ss o}f Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funer I Service Licer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failuge. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BOICEON Physician/ Drevnonio disease or condition Medical resulting in death) Due to for as a consequence of: **Examiner** mson Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be exect resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 anding purse as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed has 2 (within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence Other (Specify 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending **2** Watural 1 🗌 Yes 2 🗆 No Investigation Accident ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Marie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Christopher Jan	nes	Melton St 1- For State Registrar	ate of Maryland		artment of rtificate of		ind Mer	ntal Hygiene	Reg.	201	0 799	
Physici		1. Decedent's Name (First, Middle		7.1				2. Date	of Death	ay Year	3. Time of Death	
Medical Exami	iner	Christopher						June	4, 2010)	2114 hrs	
,		4a. Facility Name (if not institution 10406 Fair Oaks	n, give street and number	7)		4b. City, Town, Columiba		or Death		4c. County of D Howard	eatti	
Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. la	ast birthday)	If Under 1 Y		ler 24Hrs. 8. Date	of Bigth(MM/DD/YYYY) 9	Birthplace (State or	
Director		216-74-7526 222-80-8774	1x M 2 F	18	Yrs		ays Hour	1.0	UZ	-, 1991 FG	oreign Country)	
		Usual Residence of Decedent		-							Delaware	
w any		10a. State 10b. County MD HOW	ard		Town or Locat olumbi						10d. Inside City Limits 1 Yes 2 No	
Maryland 28a-f show 1 at once,	tor					10f. Zip Code			140-	Citizen of What (
5-0036 ed within 72 hours after death with the Maryland Iygiene. other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once.	Director	10e. Street and Number 10406 Fai	r Oaks				045		log.	USA	Sound y?	
h with ems 23 t be no	Funeral	11. Marital Status 1 X Never Married 2 Married 2	12. Was Deceden					igin? (Specify Yes		14. Race - A White, et	merican Indian, Black,	
er deat , or ite	Fun			X No	1	Yes 2 X			•	Specify: Black		
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	d by	15. Decedent's Education (Spe	or Dates:	mpleted)		it's Usual Occup	pation (Give	kind of work done	16	Sb. Kind of Busine	ess/Industry	
72 hou n "na	letec	Elementary/Secondary (0-12)	College (1-4 or			ost of working I	ife. DO NOT	Tuse retired)		Educat	rion	
0036 within ene. er tha	Completed	12th	N/A		St	udent						
	Be Co	17. Father's Name (First, Middle, Clyde Bes	sicks				1	r's Name (First, Mi acy M	ddle, Maid elto			
MD 2121 d 2 should be fi 1th and Mental n 27 is marked	T _o	19a. Informant's Name/Relations Shirley Melto	hip (Type, Print) On/Grandmo	ther	19b. Mailing 2544	Address (Str Druid	reet and Nui Park	mber or Rural Rou C Dr. Ba	e Number alto	r, City or Town, S	tate, Zip Code) 21215	
		20a. Method of Disposition				ition (Name of		Date		0c. Location - Cit		
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 4 Donation 5 Other Sp		tate Du	Taney	Valle	У	6/12/1) C	ckeys	$ ext{ville,MD}$	
Baltimo permit. Pag Department Important:		21. Si of Funeral Service			22. N	lame and Addre	ess of Facilit	y Betts	Fun	eral H		
	l ji	Tatua,	Getts					oline S				
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.			ne mode of dylr	ng, such as o	cardiac or respirate	ory arrest,	snock, or neart	Approximate Interval Between Onset and Death	
Examiner	2	Immediate Cause (Final disease or condition resulting in death)	a. Carbon monox								5001	
		Sequentially list conditions,	b		<u> </u>							
	iner	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence of	f):							
.1=	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of	n):							
rand ransi			d. 8	ner f	h	6-15-1	0 vt					
D, be ey siciar	edical	UNPENDED	#5 ₁	perFH	,G904,6	/9/2010	,WS			- Suece Sees		
Box 6876(death certificate the attending physical for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of pregr		tal death	3 Ectopi	ic pregnancy		23d. Date of deli Month	very Day Year	
OX 6 eath cer attendi	sicia	<u> </u>	4 Pregnant a	t time of de	ath 5 Ot	her (Specify)			- 1			
the degraphed by the graphed for	Phy	Part II. Other significant conditi	9 Onkriown	th but not re	esulting in the u	inderlying cause	e given in P	art I 23e	Did tobac	cco use contribute	e to the cause of death?	
ires that the signed by I be detached	۵						- 3		Yes 2	2 No 3	Probably 4 VI Unknown	
ords, w require s been si should b	Completed							24a.	Was an		e autopsy findings available	
e law e has ge 2 sh	du								autopsy performe Yes 2	d? deat		
Vital Rec ysician: The his certificate director, page	ပ္ပို	25. Was case referred to medical				26.Pla	ice of Death	(Check only one)	res 2	No 1 ✓	res 2 No	
Vital Rec sysician: The this certificate I director, page) B	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ent 2	ER/Outpatient	3 DOA	Other ₄	Nursing Home	5 Res	sidence 6 🗸 0	ther: Scene	
J of Jing Pl After funeral	Ë.	27. Manner of Death 1 Natural 5 Pand	28a. Date of Inj (Month, Day,) FOUND:	ury Year)	28b. Time of I FOUND:		njury at Worl	Subject		injury occurred dicarbon moi	noxide vapors	
Sior Attendar r death ector: by the	catic	Pend	stigation Jun 4, 2010		2108 hrs		Yes 2		tion /Ctro	ot and Number of	Pural Pouto Number City	
Divi spital or , nours after neral Dir filled in 1	To see the second of the secon											
Hospit 4 hour Funer	ပ	29a Certifier	nysician: To the best of m	_	ge, death occur	red at the time,	date and pl					
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical		miner:On the basis of exa									
F 3 F 3	Me	29b. Signature and title of certifie					nse number	OCME			(Month, Day, Year)	
		Theodon	Mr. King	JA	(mi)	0.0	C.M.E.		J	une 5, 2010		
6		30. Name and address of person Theodore M. King, Ir.				111 Penn S	Street Ba	altimore, MD 2	1201			
		Theodore M. King, Jr., 31. Date fled (Mooth, Day, Year)	MD. Assistant N			TI Felli S	Jucet, Da		1201			
St Regist	ate	חוות פינו עווו.	A. Rogistie	A syriatu	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ May 27, 2010 ea 1:55p Joseph Monroe М Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie North Health and Rehab Center Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) May 28, 1926 Country) Maryland 1 XM 2 | F Months Days Hours Min Director 83 220-16-4834 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s 1 Yes 2 No Pasadena Anne Arundel Marvland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral HSA 21122 804 Woods Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married "natural", or þ 1 Yes 2 No Baltimore, Maryland 21215-0036 Black 1 Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Private Company Elementary/Seconday (0-12) College (1-4 or 5+) the Construction Worker traumatic event, Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Beatrice Monroe Page 1 and 2 should be Webster Monroe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 804 Woods Road Pasadena, Maryland 21122 f Health a Annie Green 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 XBurial 2 Cremation 3 Removal from State 06/01/10 Pasadena, Md. Mt. Zion Church Cemetery 4 Donation 5 Other (Specify) 21. Signature of Service Licer 22, Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Futaw Place Baltimore, Md 21217 23a. Part 1. Enjecthe disease, or complications that caused the drath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or real failure. List only one cause in each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) executed the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death ed by the a Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de þ 1 ☐ Yes 2 ☐ Alo 3 ☐ Probably 4 ☐ Unknown Records, Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 2 X No 1 ☐ Yes 2 🔀 No certificate Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No ပု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: : After 1 work? 1 ☐ Yes 2 ☐ No Natural 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur M Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Notes Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) Scolle 208 (sayn) INYL 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MONE 2010 11:08 PM RUDOLPH MOORE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S DOCTOR'S COMMUNITY HOSPITAL LANHAM 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday 8. Date of Birth Funeral Days 1 X M 2 🗆 F Months Hours 11/21/1935 WASHINGTON, D.¢. Director 577-46-4820 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director WASHINGTON DC 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral UNITED STATES #104 20019 3723 JAY ST., NE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎛 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1X Never Married 2 Married ρ 21215-0036 Specify: BLACK 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
iffe. DO NOT use retired)
DRY CLEANING SPECIALIST 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) WILLIAM MOORE JEWEL SOLOMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1541 FT. DAVIS ST., NE WASH., DC 20020 KIMBERLY MOORE/DAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) LINCOLN MEMORIAL/CEM. 6/10/10 SUITLAND, MD. 22. Name and Address of Facility CAPITOL MORTUARY 21. Signature of Funeral Service Licensee 1425 MARYLAND AVE., NE WASHINGTON, DC 20002 Now 23a. P. rt 1. Enter the disea e. or complications that caused the death. D flot enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition LUNG cancer Physician/ Due to (or as a consequence of): Medical resulting in death) Examiner Empherema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Artery sician and burial-transit Morona death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an autopsy performed? Yes 2 X No prior to completion of cause of death? page To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) my Kernil And elly, on D0059981

State

RUDOLPH

400

DHMH 17 Rev 7/2009

Registrar

acause of death (Item 23a) (Type, Print) 12200 Annopolis Rd, Clenn Pale. MD. 20769

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

MUKEMII

9 201

31. Date filed (Month, Day, Year)